# [2022] WACOR 33

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| **JURISDICTION** | **:** | CORONER'S COURT OF WESTERN AUSTRALIA |
| **ACT** | **:** | CORONERS ACT 1996 |
| **CORONER** | **:** | Rosalinda Vincenza Clorinda Fogliani, State Coroner |
| **HEARD** | **:** | 31 AUGUST 2021 - 2 SEPTEMBER 2021 |
| **DELIVERED** | **:** | 20 JULY 2022 |
| **FILE NO/S** | **:** | CORC 6 of 2018 |
| **DECEASED** | **:** | YEEDA, SETH GREGORY VICTOR |

*Catchwords:*

Nil

*Legislation:*

Nil

## Counsel Appearing:

Sergeant A Becker assisted the State Coroner

Mr A Crocker (instructed by National Justice Project) appearing on behalf of Ms Marlene Carlton, mother of the deceased

Mr B Nelson with Ms Miller (State Solicitor's Office) appearing on behalf of the Department of Justice, Western Australian Country Health Services and Child and Adolescent Health Services

Ms L Coci and Ms G McGrath (Panetta McGrath Lawyers) appearing on behalf of the WA Cardiology

## Case(s) referred to in decision(s):

Nil

*Coroners Act 1996*
(Section 26(1))

# RECORD OF INVESTIGATION INTO DEATH

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of* ***Seth Gregory Victor YEEDA*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, between 31 August 2021 - 2 September 2021, find that the identity of the deceased person was* ***Seth Gregory Victor YEEDA*** *and that death occurred on 3 May 2018 at Derby Hospital, Derby, from rheumatic heart disease (severe aortic valve regurgitation) in the following circumstances:*

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## INTRODUCTION

**1.** Seth Gregory Victor Yeeda (Mr Yeeda) was a 19 year old Aboriginal male who tragically died at the West Kimberley Regional Prison on 3 May 2018 while serving a 14 month custodial term of imprisonment.[1]

**2.** Mr Yeeda was born in Kununurra on 1 May 1999, and he grew up there. As a young child, Mr Yeeda was diagnosed with rheumatic fever. This illness led to him suffering persisting heart damage, known as rheumatic heart disease. It was a serious cardiac disease that required regular medication and monitoring over his lifetime.

**3.** When he was just ten years old, Mr Yeeda underwent surgery for an aortic valve repair at Princess Margaret Hospital. This surgery was successful, but it was not, and did not purport to be, a cure for his rheumatic heart disease. He still required ongoing monitoring and treatment.

**4.** To prevent ongoing damage to the heart valves through recurrent bouts of rheumatic fever, throughout his life Mr Yeeda was supposed to have regular monthly intramuscular benzathine penicillin G injections (penicillin injections). These were offered to him as required, but on occasion he was resistant and refused to have them, despite the best endeavours used to explain their importance to him and/or his carer. The penicillin injections do not reverse the effects of rheumatic heart disease, but they are an important aspect of treatment as they help prevent further episodes of rheumatic fever.

**5.** On 5 May 2017, Mr Yeeda was taken into custody and he died in custody approximately one year later. At the time of his death, he had severe aortic valve regurgitation and left ventricular dilatation, as a result of the progression of his rheumatic heart disease.

**6.** Mr Yeeda's death may have been prevented if he had undergone surgery for an aortic valve replacement. He had been due to see a cardiologist, but the referral from the Prison Medical Officer was not progressed to the stage of having an appointment made for him.

**7.** If Mr Yeeda had been seen by a cardiologist as per the Prison Medical Officer's referral, it is likely that he would have been advised that he needed urgent surgery for an aortic valve replacement. It is likely that the cardiologist would have explained to Mr Yeeda that without the cardiac surgery, he faced the risk of sudden cardiac death.

[1] Exhibit 1, tab 4.

**8.** Arrangements for such surgery had previously been made for Mr Yeeda in March 2015 and March 2016, but those surgeries were cancelled due to there being no consent for them by or on behalf of Mr Yeeda. However, the fact that there had been no past consent did not mean there would be no future consent. It is known that on 5 December 2017, Mr Yeeda agreed for the Prison Medical Officer to refer him to a cardiologist. The referral was made but regrettably an appointment was not made. He died approximately 5 months later.

**9.** The focus of the inquest into Mr Yeeda's death was on the quality of his supervision, treatment and care while he was in custody, in particular at the West Kimberley Regional Prison, and specifically on the following aspects:

**a)** The efforts made to manage his cardiac disease in prison;

**b)** The reasons as to why his referral to the cardiologist was not progressed;

**c)** The efforts made to resuscitate him after his collapse on 3 May 2018; and

**d)** Whether his death may have been prevented.

## MR YEEDA

**10.** Mr Yeeda was one of five children in his family, the eldest son to his mother. His parents separated when he was still a child, and he was primarily cared for by his grandmother, due to his mothers' business commitments. He spent much of his life living in Kununurra and the Kimberley Region of Western Australia. He was from the Miriwoong cultural group.[2]

**11.** As a child Mr Yeeda enjoyed going to school and was particularly interested in mathematics and woodwork. He was good at drawing. His mother has described him as quiet and shy but very loving and happy. He was a treasured member of his family.[3]

**12.** Mr Yeeda completed his year 10 schooling at Kununurra District High School, and he then commenced a basic work skills program through the "*Yeehaa Range*" program. His mother described him finding his true

[2] Exhibit 1, tab 2; Exhibit 3, tab A; Exhibit 5.
[3] Exhibit 5.

calling in the Yeehaa Range program, namely horse-riding. He hoped one day to work on a station.[4]

**13.** Shortly before his death he was close to completing a Certificate 2 in Agriculture. He had also achieved a qualification in respect of "*Safety in the Construction Industry*" and a First Aid Certificate. He was engaged and interested, capable and future focussed.[5]

**14.** His rheumatic heart disease was a matter of great concern for him and his family. His grandmother, with whom he was close, accompanied him to many of his medical appointments. The detail of Mr Yeeda's health condition is addressed under the heading later in this finding, *Medical Background*.

**15.** Mr Yeeda's mother, and his family, continue to mourn his loss. His mother misses him every day.

## THE INQUEST

**16.** Mr Yeeda's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (the Act) and it was reported to the coroner as required by the Act.

**17.** By reason of s 19(1) of the Act I have jurisdiction to investigate Mr Yeeda's death. The holding of an inquest, as part of the investigation into his death, is mandated by reason of s 22(1)(a) of the Act. This is because immediately before death he was a person held in care by reason of being under the control, care or custody of the CEO of the Department of Justice, in accordance with the *Prisons Act 1981* (then the Department of Corrective Services).

**18.** My primary function has been to investigate Mr Yeeda's death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Act, I must find if possible, how Mr Yeeda's death occurred and the cause of his death.

**19.** Pursuant to s 25(2) of the Act, in this finding I may comment on any matter connected with Mr Yeeda's death including public health, safety or the administration of justice. This is the ancillary function.

**20.** Pursuant to s 25(3) of the Act, as Mr Yeeda was a person held in care, in this finding I must comment on the quality of his supervision, treatment

[4] Exhibit 3, tab A; Exhibit 5.
[5] Exhibit 3, tab A.

and care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

**21.** Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

**22.** Pursuant to s 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

**23.** I held an inquest into Yeeda's death and heard evidence from eleven witnesses between 31 August 2021 and 2 September 2021. I received 9 exhibits into evidence comprising 105 tabs.

**24.** After the evidence was taken at the inquest, submissions were provided to me for the purposes of s 44(2) of the Act, between 8 October 2021 and 29 October 2021.

**25.** In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

**26.** In the conduct of the inquest, and for the purposes of discharging my functions under s 25(2) and 25(3), I have taken account of the need for a thorough and independent judicial investigation of deaths in custody, as outlined by Royal Commissioner Johnston QC in the *Royal Commission into Aboriginal Deaths in Custody (1991)*, conscious of the potential for me to identify systemic failures which, if acted upon, may prevent future deaths in similar circumstances.

**27.** I adopt the views expressed by Watterson R, Brown P and McKenzie J, *Coronial Recommendations and the Prevention of Indigenous Death* (2008) 12 (SE2) Australian Indigenous Law Report (6):

> "*The Royal Commission recommended an expansion of a coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every*

*avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others*."

**28.** My findings appear below.

## RHEUMATIC HEART DISEASE GENERALLY

**29.** The Australian Institute of Health and Welfare describes acute rheumatic fever as an autoimmune response to infection of the upper respiratory tract (and possibly of the skin, following impetigo or scabies) by group A streptococcus (Strep A) bacteria. One or more episodes of acute rheumatic fever can damage heart valves, thereby causing rheumatic heart disease. An affected heart valve can become scarred and stiffer, obstructing blood flow, or it can fail to close properly, causing blood to flow backwards in the heart instead of forward around the body. This backwards flow is referred to as aortic valve regurgitation, and this is what Mr Yeeda had.[6]

**30.** The autoimmune response can be raised by the body when the infection (such as a streptococcal throat infection) is not treated with antibiotics. At the inquest the expert witness Professor David Celermajer, professor of Cardiology at the University of Sydney and clinical cardiologist at Royal Prince Alfred Hospital described rheumatic heart disease as: "*a disease of poverty, which has almost been wiped out in the non-Indigenous populations of developed countries*".[7]

**31.** A recurrence of acute rheumatic fever can cause further cardiac valve damage, and the first episode can predispose to recurrences. Rheumatic heart disease can steadily worsen in persons who have multiple episodes of acute rheumatic fever.

**32.** Following confirmation of an acute rheumatic fever diagnosis, it is recommended that penicillin injections be given every three to four weeks for approximately 10 years to prevent further recurrence of acute rheumatic fever and ongoing damage to the heart valves. For some persons, the penicillin injections can be experienced as being very painful. For a variety of reasons, including the frequency with which they are required, full compliance can become problematic.

**33.** Australia reports annually on the incidence of acute rheumatic fever and rheumatic heart disease. The information is sourced from data collected

[6] Exhibit 2, tab 8C.
[7] ts 43.

from the jurisdictional registers in Western Australia, Queensland, South Australia, and the Northern Territory.

**34.** The Australian Institute of Health and Welfare reports that Australia has one of the highest recorded rates of acute rheumatic fever and rheumatic heart disease in the world, and that it most commonly occurs during childhood, adolescence, and young adulthood. The conditions are associated with social and environmental factors such as poverty, overcrowded housing and poor functioning of "*health hardware*" such as facilities for washing people, clothes and bedding. The conditions are far more likely to occur among Aboriginal and Torres Strait Islander people living in remote communities.[8]

**35.** The Australian Institute of Health and Welfare reports on the incidence of acute rheumatic fever as follows:

**a)** "*In 2015–2019, a total of 2,244 notifications of ARF were recorded in Queensland, Western Australia, South Australia and the Northern Territory (5 per 100,000 population over the 5 years combined). During this period the number and rate of notifications increased, from 342 (4 per 100,000) cases diagnosed in 2015 to 477 (5 per 100,000) in 2019*";

**b)** "*Indigenous Australians accounted for 95% (2,128) of the ARF notifications during this period (96 per 100,000 population over the 5 years combined)*";

**c)** "*Of non-Indigenous ARF cases, 45% identified as Maori and Pacific Islander people and 12% were from other high-risk groups*".[9]

**36.** The Australian Institute of Health and Welfare reports on the incidence of rheumatic heart disease as follows:

> "*As at 31 December 2019, there were 5,385 people living with RHD recorded on the 4 jurisdictional registers. Of these, nearly 3 in 10 (1,558) were aged under 25, 2 in 3 (3,561) were females, the greatest number were living in the Northern Territory (2,308), and 4 in 5 diagnoses (4,337, 81%) were among Indigenous Australians. The median age for RHD diagnosis among Indigenous Australians (22 years) was younger than for non-Indigenous Australians (50 years)*".[10]

[8] Exhibit 2, tab 8C.
[9] Ibid.
[10] Ibid.

**37.** Under its "*Rheumatic Fever Strategy*" the Australian Government provides funding to support rheumatic heart disease control programs in the above jurisdictions.

**38.** An inquiry into the rheumatic heart disease control programs is outside the scope of the inquest. The incidence of rheumatic heart disease amongst the Aboriginal and Torres Strait Islander community is referred to above as it places Mr Yeeda's medical history into context.

**39.** It demonstrates the need for an awareness of the prevailing health conditions amongst vulnerable groups of the population, and the need for an awareness of the social determinants of ill health. Relevantly for the purposes of the inquest, this awareness is important for when such persons are in custody, with the State being ultimately responsible for their supervision, treatment and care.

## MEDICAL BACKGROUND

### Early diagnosis and Surgery

**40.** In 2008 when Mr Yeeda was still a young child, he was diagnosed with acute rheumatic fever. He was monitored and started on monthly penicillin injections. He attended medical appointments, however records reflect that Mr Yeeda did not receive many of his scheduled monthly penicillin injections.

**41.** In July 2009 Mr Yeeda was brought to Perth and reviewed by the Paediatric Cardiologist at the Princess Margaret Hospital Outpatient Clinic. He was diagnosed with severe aortic valve regurgitation (leaking of the aortic valve, a known complication of acute rheumatic fever). Medical reviews continued and on 2 December 2009, when he was ten years old, he underwent successful surgery at Princess Margaret Hospital for an aortic valve repair. The repair was essentially performed by putting extra tissue on the valve, rather than replacing it.[11]

**42.** Mr Yeeda was accompanied to Perth for this surgery by his grandmother. Post-operatively he did well, and he travelled back to Kununurra in mid-December 2009. He returned to Perth for his two-month post-operative review at Princess Margaret Hospital, and was found to be clinically well.[12]

[11] Exhibit 2, tab 8B; ts 99.
[12] Ibid.

## Medical Reviews

**43.** Mr Yeeda's health continued to be monitored, with reviews by the Visiting Regional Paediatric Cardiologist at the Ord Valley Aboriginal Health Service on 19 August 2010 (where it was noted that he was refusing his penicillin injections) and in May 2012 (where it appeared that compliance improved, and he was receiving approximately 80% of his penicillin injections). At this stage he had not had a recurrence of rheumatic fever, and his echocardiogram was stable. He was then thirteen years old.[13]

**44.** For reasons outside his control, on occasion Mr Yeeda missed some scheduled cardiology reviews at the Ord Valley Aboriginal Health Service (in April 2013 and a follow up in April 2014).[14]

**45.** On 4 September 2013 Mr Yeeda was conveyed to Princess Margaret Hospital, for review by the Paediatric Cardiologist. At this review it was noted that Mr Yeeda had not had any documented recurrences of acute rheumatic fever, but that his echocardiography showed an increase in the severity of his aortic valve regurgitation. Mr Yeeda reported that he was playing basketball and football, and he denied any cardiac symptoms.[15]

**46.** On this occasion Mr Yeeda's compliance with his penicillin injections was noted as being poor. The Paediatric Cardiologist tried to persuade Mr Yeeda to take his scheduled injections and to explain the consequences if he continued to refuse. Follow up in Kununurra was planned for him.[16]

**47.** Mr Yeeda was next conveyed to Princess Margaret Hospital for a consult with the Paediatric Cardiology Fellow on 3 October 2014. It had recently been confirmed that his previous penicillin injection was back in August 2013, and he was given an injection on 1 October 2014, a couple of days before being taken to Princess Margaret Hospital.[17]

**48.** At Mr Yeeda's 3 October 2014 review at Princess Margaret Hospital, medically it was noted that there was a change for the worse. His echocardiogram now showed severe aortic valve regurgitation. The aortic valve was more thickened with a mild degree of aortic stenosis (narrowing of the valve). He also had a severely dilated left ventricle

[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.

(but with a normal systolic function). He was still apparently asymptomatic and reported playing basketball without problem.[18]

**49.** However, it now seemed inevitable that Mr Yeeda would need surgery for a replacement of his aortic valve. Initially the further surgery was scheduled for 4 March 2015, but it was cancelled. This was due to there being no agreement for surgery from Mr Yeeda, nor ultimately from his grandmother or family.[19]

**50.** On 21 April 2015 the Visiting Paediatric Cardiologist at Kununurra (who was aware of his medical history) reported back to the Ord Valley Aboriginal Health Service that Mr Yeeda had attended the clinic on his own on 17 April 2015 for review (due to his grandmother being unwell).[20]

**51.** At this review, Mr Yeeda's echocardiogram results were like those in 2014 (he still had the severe aortic valve regurgitation, and his left ventricular size and function were like before). The Visiting Paediatric Cardiologist noted that Mr Yeeda was at high risk of endocarditis.[21]

**52.** It is clear that at the 17 April 2015 cardiology review, focussed attempts were made to explain the concerns about his heart to Mr Yeeda, but the Visiting Paediatric Cardiologist was not able to engage him in conversation about it, finding him to be both scared and shy. He resolved to discuss it further with Mr Yeeda's grandmother and review him in six months' time.[22]

**53.** At this same review it was also noted by the Visiting Paediatric Cardiologist that Mr Yeeda had not had his penicillin injections. Efforts continued to persuade him to have his penicillin injections.[23]

**54.** The penicillin injections do not improve the function of the aortic valve, but they are important because their role is to prevent the condition from worsening. If the person suffers more instances rheumatic fever, on top of their rheumatic carditis, the valve damage is accelerated.[24]

**55.** The six-month follow-up appointment was scheduled for Mr Yeeda at the Ord Valley Aboriginal Health Service on 19 October 2015, but he

[18] Ibid.
[19] Exhibit 1, tab 39C; Exhibit 2, tab 14.
[20] Exhibit 2, tabs 8B and 8C; Exhibit 2, tab 14; ts 104.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Exhibit 2, tabs 8B and 8C; ts 46; ts 118.

did not attend. The Ord Valley Aboriginal Health Service subsequently managed to speak with Mr Yeeda's grandmother by telephone, and another plan for surgery was made for early March 2016. However, this was cancelled by the family prior to travel to Perth.[25]

**56.** In late May 2016, clinicians had some focussed discussions with Mr Yeeda with the aim of impressing upon him the nature of his rheumatic heart disease, the damage done to his heart and the potential damage if he remained non-compliant or failed to attend a cardiology review. Mr Yeeda refused to attend a cardiology review.[26]

**57.** The clinicians formed the view that Mr Yeeda had capacity to make the decision to refuse to attend a cardiology review and that he was aware that the consequences of not attending (and remaining non-compliant) may be "*an uncomfortable death from heart failure*". Nonetheless it is to be understood that Mr Yeeda was only 17 years old at the time, and that while strictly speaking he may have had capacity to refuse, efforts to encourage him should continue, and they did continue.[27]

**58.** The Ord Valley Aboriginal Health Service offered Mr Yeeda Paediatric Cardiology appointments in May and July 2017 but Mr Yeeda was not able to attend either of them (over this period Mr Yeeda was in custody).[28]

**59.** Specifically, on 31 May 2017 the Visiting Paediatric Cardiologist recorded, for the Ord Valley Aboriginal Health Service, that Mr Yeeda did not attend the Kununurra Hospital Visiting Paediatric Cardiology Clinic on 16 May 2017 by reason of apparently being in detention (which was correct, he was at Albany Regional Prison) and expressed the view that Mr Yeeda needed cardiology follow-up by the adult physician at WA Cardiology. At this stage Mr Yeeda had just turned 18 years old.[29]

**60.** As a consequence, the Ord Valley Aboriginal Health Service referred Mr Yeeda to a cardiologist from WA Cardiology, and an appointment was made for him to be seen by the Visiting Cardiologist (as an adult) on 17 July 2017. However, Mr Yeeda did not attend by reason of being in custody (he was still at Albany Regional Prison). The Visiting Cardiologist from WA Cardiology reported to Ord Valley Aboriginal

[25] Exhibit 1, tab 39; Exhibit 2, tabs 8B and 8C.
[26] Exhibit 2, tab 12.
[27] Ibid.
[28] Exhibits 4.1 and 4.2
[29] Exhibit 4.1.

Health Service that he would try to arrange another echocardiogram and cardiology review.[30]

**61.** After he went into custody as an adult on 5 May 2017, Mr Yeeda did not have any further reviews by a cardiologist, despite early attempts to refer him being made in June and July 2017. He died as a result of complications from his rheumatic heart disease on 3 May 2018. As of 5 December 2017 Mr Yeeda agreed to a referral to a cardiologist, but for reasons that were explored at the inquest, this referral did not progress to the stage of an appointment being made for him. In this finding, this is referred to as the referral not being progressed. This is addressed later in this finding under the heading: *Mr Yeeda's cardiology referral*.

## ADULT CUSTODIAL HISTORY

**62.** On 5 May 2017 a Warrant of Commitment issued for Mr Yeeda to be imprisoned for one year and two months, with eligibility for parole. On 17 October 2017, Mr Yeeda was denied parole, with reasons being provided to him. He remained in custody until his death on 3 May 2018.[31]

**63.** As an adult Mr Yeeda was imprisoned and placed in the following facilities:

**a)** Hakea Prison – 5 May to 13 May 2017;

**b)** Albany Regional Prison – 13 May to 1 August 2017;

**c)** Casuarina Prison – 1 August to 3 August 2017;

**d)** Greenough Regional Prison – 3 August to 30 November 2017;

**e)** West Kimberley Regional Prison – 1 December 2017 to 3 May 2018.[32]

**64.** I have reviewed Mr Yeeda's adult custodial history in order to comment on the quality of his supervision, treatment and care. The main area of focus concerned Mr Yeeda's need for a cardiology review by a specialist cardiologist. If this had occurred, it would likely have resulted in a firm recommendation to him that he have heart valve replacement surgery, to save his life.

[30] Exhibit 4.2.
[31] Exhibit 1, tabs 23, 25, 26 and 27.
[32] Exhibit 1, tab 3; Exhibit 3, tab A.

**65.** Despite being urged to do so, Mr Yeeda initially refused to attend outside cardiology appointments (meaning external to the prison). The procedure would likely have been to shackle him for these external appointments, and he did not want that, as he felt shame at the prospect of being shackled. Further, his expressed preference was to have his grandmother attend with him, to explain what the doctor would say, once he returned to the Kimberley Region. [33]

**66.** Once Mr Yeeda was admitted to the West Kimberley Regional Prison at Derby, he did promptly agree to a referral to a cardiologist, but for reasons that were explored at the inquest, the referral was not progressed.

**67.** In terms of the preventative care, it is to be noted that he received all his scheduled monthly penicillin injections within the prisons over the period that he was in custody, which was a marked improvement upon his compliance in the community.

**68.** The details of Mr Yeeda's prison reception intake and prison transfers appear below.

## Reception intake at Hakea Prison

**69.** On 8 May 2017 Mr Yeeda underwent a medical examination shortly after his admission to Hakea Prison. His Corrective Services medical records (EcHO records) record his rheumatic heart disease and a plan for discussion with another doctor for cardiac follow up and an echocardiogram. For various reasons, whilst the requirement was identified early in his custodial term, the cardiac follow up with a cardiologist, which is what was required for him, did not ultimately occur.[34]

**70.** Between 8 and 11 May 2017 Mr Yeeda was further reviewed by the Prison Medical Officer at Hakea Prison. It was noted that his ECG's showed left ventricular hypertrophy (enlargement of the heart) and T wave inversion inferiority. It was recommended that the results of his ECG's be reviewed by a cardiologist. It is not apparent that this occurred.[35]

**71.** The reception intake assessment records also reflect an initial referral for Mr Yeeda to the At-Risk Management System (ARMS) and initial placement within Crisis Care until he was assessed as future focussed

[33] Exhibit 2, tab 12.
[34] Exhibit 2, tab 12.
[35] Ibid.

and with no risk to himself. Mr Yeeda was identified as an "*out of country*" Indigenous prisoner and referred to the Prison Support Officer. These aspects were appropriately addressed.[36]

**72.** In May 2017 Mr Yeeda's security rating was reduced to "*medium*". He was moved from Hakea Prison to Albany Regional Prison on 13 May 2017 to develop his Individual Management Plan. At an early stage he had expressed a preference for serving his sentence at the West Kimberley Regional Prison, due to his family being in Kununurra. As will be seen, he was transferred there later in the year.[37]

## Transfer to Albany Regional Prison

**73.** On 18 May 2017, shortly after his arrival at Albany Regional Prison, the Clinical Nurse undertook a Cardiac and Cardiovascular Care Plan review. The Clinical Nurse had access to Mr Yeeda's recent ECG's and reviewed them together with the Prison Medical Officer. On this date Mr Yeeda was recorded as not being fit for sports nor strenuous activity, and as requiring medical assessment, specifically echocardiogram and cardiology follow up.[38]

**74.** On 23 May 2017 the Prison Medical Officer at Albany Regional Prison reviewed Mr Yeeda, blood tests were ordered, and it was documented that he was to be referred for cardiology review. When the Prison Officer again reviewed Mr Yeeda on 22 June 2017, the blood tests came back as normal. During that review, and a few days later with the clinical nurse, Mr Yeeda expressed reluctance about seeing a cardiologist. He did not want to go outside Albany Regional Prison for medical attention and for the reasons outlined previously, expressed the desire to wait until he returned home to Kununurra.[39]

**75.** When the Prison Medical Officer reviewed Mr Yeeda again at Albany Regional Prison on 24 July 2017, Mr Yeeda again refused to attend appointments outside the prison, expressing the desire to have family present.[40]

**76.** In terms of his social needs at Albany Regional Prison, he linked up with countrymen and was observed to maintain regular telephone contact with his family in Kununurra. He was described as a gentle and quiet prisoner who abided by the prison regime, interacted well with peers and

[36] Exhibit 2, tabs 1 to 3; Exhibit 3, tab A
[37] Ibid.
[38] Exhibit 2, tab 12.
[39] Ibid.
[40] Ibid.

was respectful to staff. He obtained employment as a cleaner within his unit, supervised. The prison officers were aware that Mr Yeeda had a heart condition and should not be doing any strenuous activities.[41]

**77.** An Individual Management Plan was developed for Mr Yeeda, which included cognitive skills treatment interventions. In accordance with his then expressed desire, arrangements were made to transfer him to Greenough Regional Prison, via Casuarina Prison.[42]

## Transfer to Greenough Regional Prison

**78.** Mr Yeeda was admitted into Greenough Regional Prison on 3 August 2017 and was held there for approximately three months. In terms of his social needs, he was again identified as an "*out of country*" Indigenous prisoner and referred to the Prison Support Officer, who noted him to be settled and engaged with countrymen. He obtained employment as a bin's leader in the industrial area and was described as a punctual worker who completed his tasks as required.[43]

**79.** At Greenough Regional Prison Mr Yeeda successfully completed his Certificate 1 Entry to General Education – Introduction to Workplace Health and Safety. He also completed the Department of Transport's Keys for Life Pre-Driver program.

**80.** As is known, he had requested a transfer to West Kimberley Regional Prison. In November 2017 his security rating was reduced to "*minimum*", and arrangements were made to transfer him to West Kimberley Regional Prison, which would facilitate social visits with his family.[44]

## Transfer to West Kimberley Regional Prison

**81.** Mr Yeeda was admitted to West Kimberley Regional Prison on 1 December 2017. Shortly afterwards on 5 December 2017 he was reviewed by the Prison Medical Officer Dr Roger Todd (Dr Todd), who was a witness at the inquest. Dr Todd was the only medical officer at the West Kimberley Regional Prison at the material time.[45]

[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Ibid; Exhibit 1, tab 28; Exhibit 2, tab 1.
[45] Exhibit 2, tab 12.

**82.** On that same day, 5 December 2017, Dr Todd completed a referral for Mr Yeeda for an "*urgent*" (within 30 days) cardiology review with the Visiting Cardiologist, and an echocardiogram appointment. Dr Todd was able to persuade Mr Yeeda of the importance of a cardiology review. Mr Yeeda was now in the Kimberley Region, and more comfortable attending an external appointment.[46]

**83.** In terms of physical activity, Dr Todd also noted that Mr Yeeda did not play sport as his grandmother forbade it. In fact, leaving aside the matter of whether a family member had forbidden it, the West Kimberley Regional Prison should have encouraged Mr Yeeda not to engage in vigorous exercise due to his heart disease. This is addressed in more detail later in this finding under the heading: *The effect of vigorous exercise*.[47]

**84.** Dr Todd reviewed Mr Yeeda again at West Kimberley Regional Prison on 25 January 2018. On that date Dr Todd made or commenced another referral form for a cardiology review for Mr Yeeda, having become aware that the previous referral of 5 December 2017 had not been progressed due to an apparent change in service provider.[48]

**85.** On that same date, 25 January 2018, Dr Todd also prepared a Cardiovascular Disease Care Plan and it was recorded that Mr Yeeda was booked to see a cardiologist and have an echocardiogram.[49]

**86.** The cardiology referral was not progressed for the reasons outlined later in this finding under the headings *Transition of Cardiology Service* and *Mr Yeeda's Cardiology Referral*.

**87.** In terms of his social needs, it is noted that at West Kimberley Regional Prison, Mr Yeeda was no longer "*out of country*". The Prison Support Officer noted he received visits from family members and had support from other males he knew within the prison. He obtained employment as General Worker and completed his mandatory Work Health and Safety course.[50]

**88.** Mr Yeeda's history of good prison conduct was noted at West Kimberley Regional Prison and as of February 2018, he was in the process of being assessed for external activities or work camp placement.

[46] Ibid
[47] Ibid.
[48] Ibid
[49] Ibid.
[50] Ibid.

## TRANSITION OF THE CARDIOLOGY SERVICE

**89.** At the inquest it was posited that one of the reasons as to why Mr Yeeda's cardiology referral was not progressed can be traced back to the fact that the Visiting Cardiology service was being transitioned from one external provider to another, at the time that Mr Yeeda's referral was due to be progressed.

**90.** This is not an excuse or justification for the failure to progress the referral. The transitioning of the service provider was explored at the inquest in order to examine a relevant circumstance attending Mr Yeeda's death, and also for the purpose of considering ways of avoiding the future risk of a patient essentially falling through the gaps in a transition process.

### Provision of Visiting Cardiology service

**91.** At the material time, WA Country Health Service in the Kimberley Region (WACHS-K) was responsible for delivering a Visiting Cardiology service to that region, that was accessible to prisoners requiring specialist cardiology care and treatment. This included their Visiting Cardiology service at the clinic at Derby Hospital, and it was delivered through an external specialist provider.[51]

**92.** At around the time that Mr Yeeda's referral was due to be actioned for an appointment to be made for him to be seen by the Visiting Cardiologist at the Derby Hospital, the external specialist provider changed from WA Cardiology, a long-term provider of this service, to Perth Cardiovascular Institute, the new provider.

**93.** WA Cardiology had commenced providing visiting adult cardiology and echocardiography services to the Kimberley Region in about 2002. From 2006 they employed a cardiac sonographer to be permanently based in the region to undertake echocardiography.[52]

**94.** In 2011 WACHS-K had entered into a Memorandum of Understanding (MOU) with WA Cardiology for the extension of their Visiting Cardiologist and echocardiography services to the Kimberley Health Service for a further three years.[53]

[51] Exhibit 2, tabs 9 and 9A.
[52] Exhibit 2, tab 27.
[53] Exhibit 2, tabs 20 to 23; Exhibit 2, tab 27.

**95.** Under this arrangement, WA Cardiology were generally scheduled to conduct six visits each year by the Visiting Cardiologist (of five days duration) to the west and east Kimberley Regions. They generally took place around every eight to 12 weeks. In broad terms this arrangement continued to apply until the transition to the new service provider, Perth Cardiovascular Institute at the beginning of 2018.[54]

**96.** A planner for visiting medical specialists, that included the Visiting Cardiologists, was distributed each year. The Visiting Cardiologists did not generally attend the prisons at that stage. Instead, the prisoners were conveyed to the local health service, such as Derby Hospital. By agreement with WACHS-K, WA Cardiology bulk billed the consultation for the patients seen to Medicare.[55]

**97.** At the material time when a patient was referred to WA Cardiology for cardiology services, their names and details were added to a Wait List. Under the MOU, WACHS-K paid a monthly fee to WA Cardiology for the management of the Wait List for cardiology patients in the Kimberley Region.[56]

**98.** There was an increasingly high demand for cardiology services in the Kimberley Region. The overall frequency of the Visiting Cardiologists' scheduled visits was affected by the availability of a specialist, and on occasion, accessibility to the Kimberley Region. This meant that a number of patients waited for some time to be seen. While the average time for a patient to remain on the Wait List in the Kimberley Region as a whole was some 177 days, Derby was a relatively small site, and the wait times were not very long.[57]

**99.** Nonetheless, patients who were denoted "*urgent*" on a cardiology referral form, who ordinarily ought to have been seen by the Visiting Cardiologist within 30 days, were sometimes not seen within that time frame. In terms of the management of their referral, those patients were described as being "*over boundary*" (meaning they should have been seen earlier).[58]

**100.** Under the MOU with WACSH-K, WA Cardiology was responsible for triaging the patients on the Wait List. Prior to each visit to the region, WA Cardiology would send the relevant hospital clinic (such as the

[54] Ibid.
[55] Exhibit 2, tabs 9 and 9A; Exhibit 2, tab 27; ts 20.
[56] Exhibit 2, tabs 9 and 27.
[57] Exhibit 2, tab 9A.
[58] Ibid.

clinic at Derby Hospital) the list of patients required to be booked for that visit.[59]

**101.** Most commonly patient referrals were sent by the GP directly to WA Cardiology, for triage. However, if the referral was sent to the local health service (such as Derby Hospital) it would usually be forwarded by the health service to WA Cardiology for triage. The triage was required to be undertaken by a cardiologist, before a referral could be progressed. There were no regionally based clinicians who had the expertise to triage a cardiology referral.[60]

**102.** The MOU with WA Cardiology was due to expire on 31 December 2017. This was some months prior to Mr Yeeda's death, and close to the time that his cardiology referral was made by Dr Todd. The tender for the external cardiology service was issued and a new cardiology provider was selected, being Perth Cardiovascular Institute. The result was that WA Cardiology were no longer the providers for the Visiting Cardiologist service to the Kimberley Region under the MOU after 31 December 2017.[61]

**103.** The last clinic conducted by WA Cardiology in the Kimberley Region was 4 to 8 December 2017. On 1 January 2018 Perth Cardiovascular Institute commenced as the provider of the Visiting Cardiologist services for WACHS-K. The reasons for the newly selected cardiology service provider are outside the scope of the inquest.[62]

**104.** Highly relevant to the inquest, however, was the manner in which Mr Yeeda's pre-existing cardiology referral was progressed, in the course of the transition of service from WA Cardiology to Perth Cardiovascular Institute.

## Patient information was not transitioned

**105.** WA Cardiology held all of the information about the patients referred on the Wait List that they managed under their MOU with WACHS-K. During the transition period, on a number of occasions WA Cardiology was requested by WACHS-K and the Department of Health to make the Wait List information available so that essentially Perth Cardiovascular Institute could take over their role and commence care and treatment of those patients that were waiting.[63]

[59] Exhibit 2, Tab 9A; ts 15.
[60] Ibid.
[61] Exhibit 2, tab 9.
[62] Exhibit 2, tab 27
[63] Ibid.

**106.** WA Cardiology did not pass the Wait List information (or patient information) on to Perth Cardiovascular Institute or to WACHS-K in December 2017/January 2018, and this became a source of some concern, and friction, at the material time. It became apparent at the inquest that:

**a)** WA Cardiology had formed the view that the patient details that they had were confidential, and they should not pass such details on to Perth Cardiovascular Institute (nor on to WACHS-K for onforwarding on to Perth Cardiovascular Institute); and

**b)** for reasons outlined below, WA Cardiology had formed the view that they no longer held a "*Wait List*" as such.

**107.** Associate Professor Christopher Judkins (Professor Judkins), interventional cardiologist and, at the time of the inquest, Director of WA Cardiology, provided a statement to the coroner and gave evidence at the inquest.[64]

**108.** Professor Judkins explained that any referral that was made in December 2017 (such as that for Mr Yeeda) would not be picked up on their Wait List. This was because:

**a)** The list of outpatients for the 4 to 8 December 2017 clinic was in effect the last of their lists, and there would be no further list produced by WA Cardiology for the first of the 2018 clinics because that clinic would be taken over by Perth Cardiovascular Institute; and

**b)** Dr Todd's referral dated 5 December 2017, for Mr Yeeda to be seen within 30 days, would not have resulted in an appointment during WA Cardiology's 4 to 8 December 2017 clinic.[65]

**109.** Professor Judkins was not in charge of WA Cardiology at the material time, and he gave evidence from his knowledge and review of records. His statement and evidence at the inquest comprised the first time, to the knowledge of WACHS-K, that the matter of confidentiality has been raised by WA Cardiology as the obstacle, essentially, to passing on the information they had requested in order for Perth Cardiovascular Institute to take over their role.

[64] Exhibit 2, tab 27; ts 35 to 40; ts 61 to 97
[65] Exhibit 2, tab 27; ts 91 to 92.

**110.** Dr Suzanne Phillips (Dr Phillips), Regional Medical Director WACHS-K as at the time of the inquest, reviewed the relevant records, prepared reports for the coroner and gave evidence at the inquest regarding the issues surrounding the Wait List information during the transition of the cardiology service from WA Cardiology to Perth Cardiovascular Institute. Dr Phillips was not the Regional Medical Director at the material time.[66]

**111.** Between November 2017 and January 2018, there were communications to WA Cardiology regarding the transition of services, with the aim of having WA Cardiology provide the details of the patients on the Wait List, or essentially, the patients who had been referred to that service under the MOU, and not been seen by the cardiologist.[67]

**112.** Requests to this effect were made by WACHS-K and by the Director General of the Department of Health. In addition, Perth Cardiovascular Institute sought to meet with WA Cardiology for the purpose of facilitating the transition. As is known the Wait List information was not passed on by WA Cardiology. Perth Cardiovascular Institute's request for a meeting was declined by WA Cardiology due to competing priorities.[68]

**113.** At the inquest Dr Phillips explained that the patients listed as Category 1 on the Wait List maintained by WA Cardiology were a priority for the transition to happen seamlessly, because of their clinical condition and clinical risk. Dr Phillips' understanding was that WA Cardiology had the original referrals for all the patients that had been referred to them, that those patients were in fact WACHS patients, and that WA Cardiology were under a contractual obligation to provide that information to WACHS (in this respect, references to WACHS incorporate references to WACHS-K).[69]

**114.** Dr Phillips' view was that WACHS was ultimately responsible for the care of the patients on WA Cardiology's Wait List. I accept that characterisation. She was only recently made aware that WA Cardiology felt that the patients were theirs. This did not alter her view as to WACHS being responsible for those patients. [70]

[66] Exhibit 2, tabs 9 and 9A; ts 11 to 32.
[67] Exhibit 2, tabs 24 to 26.
[68] Ibid.
[69] ts 9 to 11.
[70] ts 12; ts 26; ts 31 to 32.

**115.** Dr Phillips' evidence was that WACHS had an expectation that WA Cardiology would not treat these patients as their private patients but would be handing that information over to the next provider as identified by WACHS. Further, that WA Cardiology would inform WACHS of those patients who were "*over boundary*" meaning overdue to be seen by a cardiologist.[71]

**116.** This was in contrast to Professor Judkins' evidence to the effect that the patients that WA Cardiology were seeing under the MOU were patients of WA Cardiology. In support he pointed to the bulk billing and the fact that while WACHS-K provided the clinic facilities (such as a clinic room at Derby Hospital) WA Cardiology provided the necessary equipment for undertaking the consultations.[72]

**117.** Professor Judkins' evidence was that WA Cardiology did not feel comfortable releasing Mr Yeeda's patient information to anyone other than Dr Todd, and considered that to be consistent with privacy legislation, usual medical practice and WA Cardiology's usual practice. He explained that the process was for WA Cardiology to write brief notes in the hospital record for each patient consulted at the hospital clinic. Then the Visiting Cardiologist would usually send a letter essentially reporting back to the referring doctor, with a copy kept on WA Cardiology's files.[73]

**118.** At the material time, WA Cardiology did not inform Perth Cardiovascular Institute (nor WACHS-K) that its decision not to provide the requested patient information was due to privacy concerns.

**119.** Dr Phillips was understandably concerned and surprised to discover, at the time of the inquest, that WA Cardiology's reluctance to pass on the Wait List was actually all about patient confidentiality concerns. Her evidence, quite logically, was that if WACHS-K had known at the time that the reason for WA Cardiology not passing on the information was due to their perception that the patients were theirs, and therefore subject to confidentiality requirements, a further conversation may have been able to be held.[74]

**120.** At the inquest Professor Judkins expressed the view that patient privacy issues are quite an opaque area in the context of the matters under consideration. He also considered, that in terms of WA Cardiology's communication back to Perth Cardiovascular Institute at the material

[71] Ibid
[72] Exhibit 2, tab 27.
[73] Exhibit 2, tab 27; ts 35; ts 37 to 40; ts 55.
[74] Exhibit 2, tab 24.

time, it would have been a very sensible idea to have been more explicit regarding those privacy reasons. Professor Judkins conceded that aspect was poorly communicated by WA Cardiology.[75]

**121.** That concession was appropriately and fairly made by Professor Judkins. The most obvious step would have been for WA Cardiology to inform WACHS-K or Perth Cardiovascular Institute at the material time that it did not feel able to pass on the Wait List because it may breach patient confidentiality.

**122.** This would have provided the parties with an opportunity to explore those privacy concerns and open a discussion as to whose patients they were, and which entity owed the duty of confidence. A vital opportunity to resolve the issue, and potentially ascertain that Mr Yeeda's referral required progression, was lost.

**123.** Instead, there are email exchanges between WA Cardiology and Perth Cardiovascular Institute in November 2017, concerning the transition, that show a distinct lack of helpfulness from WA Cardiology, with no attempt to explain their patient confidentiality concerns on the face of those communications.

**124.** By email Perth Cardiovascular Institute sought the information about the patients and was essentially informed by WA Cardiology in response that WACHS has that information because the referring doctor (being a WACHS doctor) will have received a report back, and a management plan has been put in place for all patients such that there is effectively no Wait List.[76]

**125.** At the inquest Professor Judkins' attention was drawn to WA Cardiology's email of 8 November 2017 where, in response to Perth Cardiovascular Institute's request to meet in order to chat about a transition plan and continue the patient care, WA Cardiology, citing their transition to new software as occupying their time, responded with a recommendation that Perth Cardiovascular Institute: "*seek guidance from WACHS-K regarding the Kimberley cardiology service*."[77]

**126.** Upon questioning Professor Judkins agreed it was not responsive to Perth Cardiovascular Institute, and that it was not a particularly helpful communication. That concession was appropriately and fairly made.[78]

[75] Exhibit 2, tab 27; ts 35; ts 37 to 40; ts 55; ts 81; ts 85; ts 93.
[76] Exhibit 2, tab 24.
[77] Exhibit 2, tab 25.
[78] ts 84.

**127.** Professor Judkins agreed that, in terms of the best interests of the patients, it would have been preferable had there been communication by WA Cardiology to WACHS of at least a list of patients, without further detail as to clinical condition, outlining whether they had been seen or not. These were the types of options that could have been the subject of productive discussions.[79]

**128.** At the material time, WACHS and Department of Health were aware of the reluctance on the part of WA Cardiology to pass the patient information on to the new provider Perth Cardiovascular Institute and at the inquest reference was made to there being "*acrimony*" and "*conflict*" in respect of how the two services were transitioning.[80]

**129.** A complicating factor was that WA Cardiology, maintaining that the patients were theirs, kept the original cardiology referrals from the GP's, and these referrals did not necessarily go back to the patients' clinical health records maintained by WACHS-K.[81]

**130.** One consequence of this system was that WACHS-K remained unaware of the patients on WA Cardiology's Wait List. At the inquest, Dr Phillips described it as part of the crux of the problem and accepted that it was a failing. That concession was appropriately and fairly made. The manner in which it has been addressed in WACHS-K's future dealings with Perth Cardiovascular Institute is outlined under the heading *Improvements: WA Country Health Service*, later in this finding.[82]

**131.** WA Cardiology for their part maintained that they dealt directly with the referring doctors. They advised them that their visiting service to Derby would be ceasing and offered options that included their visiting service to Broome (impractical for Mr Yeeda), and the transfer of care to the new provider (Perth Cardiovascular Institute) which would require a fresh referral to that provider. This is addressed in more detail under the heading below: *Mr Yeeda's cardiology referral*.[83]

**132.** I have considered WA Cardiology's view to the effect that the referred patients were their private patients exclusively, but am not persuaded that this was the case, noting the following:

[79] ts 93.
[80] ts 27.
[81] ts 23.
[82] Exhibit 2, tab 9A; ts 22 to 23.
[83] ts 28; ts 67.

**a)** it was not a view they expressed to WACHS-K, nor to Perth Cardiovascular Institute at the material time; and

**b)** it does not align with the terms of WA Cardiology's own submission to WACHS-K for the provision of a cardiology service in the Kimberley region, which contains the following in connection with the patients on the Wait List:

"*WA Cardiology has recently appointed a Kimberley Co-ordinator and invested significant resources into developing a waitlist management service* ***for patients of WACHS-K***." (emphasis added) [84]

**133.** Whilst it is not necessary for me to reach a view on the parties' contractual obligations and bearing in mind that s 25(5) of the Act prohibits me from appearing to determine any question of civil liability, it is nonetheless relevant for me to consider the issue of whose patient Mr Yeeda was.

**134.** I am satisfied that while Mr Yeeda was clearly a patient of WA Cardiology (having been referred to them), WACHS-K was ultimately responsible for him, as the referred patient. It would have been appropriate for WA Cardiology to explain their confidentiality concerns to WACHS-K at the material time, so that discussions may have commenced about how to address the problem of WACHS-K not knowing who was on WA Cardiology's Wait List.

**135.** These issues can emerge where a governmental entity (such as WACHS-K) contracts with an external private entity (such as WA Cardiology) for the provision of service. The improvements in the area of governance are outlined under the heading *Improvements: WA Country Health Service*, later in this finding.

**136.** At the inquest Dr Phillips testified that after Mr Yeeda's death, WACHS (or Health) became aware that there were some 400 referrals that went "*missing*" in the process of transition from WA Cardiology to Perth Cardiovascular Institute. This became the subject of an audit that is referred to later in this finding.[85]

## Was there a "Wait List"?

**137.** I have considered the question of whether there was a Wait List at the time of the transition, after WA Cardiology's final clinic from 4 to 8 December 2017. I am satisfied that whether it is called a "*Wait List*" or

[84] Exhibit 2, tab 20; ts 26; ts 80 to 81.
[85] ts 28.

"*List*", there was within the possession of WA Cardiology, information about patients that had been referred to them under the MOU with WACHS-K, but not yet seen by them.

**138.** The patients that had not been seen by WA Cardiology prior to the expiration of their functions under the MOU would likely include patients who had only recently been referred to WA Cardiology, and/or patients who had not shown up at their prior appointment times. I am satisfied that such information could have been gathered by WA Cardiology into list.

**139.** As at the expiration of the MOU, those patients were waiting to be seen by the Visiting Cardiologist (or possibly still waiting to be triaged). They might have elected to stay with WA Cardiology and be seen in Broome or Perth, but if for example they needed or wanted to be seen in Derby, they would need to be seen by the Visiting Cardiologist from the new provider, Perth Cardiovascular Institute. Self-evidently, WACHS-K and Perth Cardiovascular Institute needed to know who had been referred to WA Cardiology under the MOU, but not seen (or triaged) by WA Cardiology's Visiting Cardiologist.

**140.** Professor Judkins referred to WA Cardiology's commercial interest in the provision of cardiology care to patients in the Kimberley Region over many years and to the disappointment within WA Cardiology at not having their contract renewed with WACHS.[86]

**141.** That is a frank assessment and brings into focus the question of whether WA Cardiology's reluctance to pass on the Wait List might have been affected by an element of commercial concern about the potential loss of patients to Perth Cardiovascular Institute. I have considered this question and accept Professor Judkins' subsequent evidence that WA Cardiology did not attach weight to this commercial consideration at the material time, and that patient care was at the centre of their considerations, as it ought to be.[87]

**142.** I do not consider that there was any reasonable cause for concern that upon being apprised of the patient names, Perth Cardiovascular Institute would seek to persuade those patients to transition to them, as opposed to being seen by WA Cardiology in Broome or Perth. I am satisfied that the purpose of seeking the Wait List was to see and/or treat patients who had been referred to WA Cardiology's Visiting Cardiologist and had not yet been seen (or triaged) and/or who needed treatment.

[86] ts 81 to 83.
[87] Ibid.

**143.** Professor Judkins posited that as a result of the discharges back to the referring GPs, there was no *"Wait List"* as such by the time that WA Cardiology ceased providing its services. At the inquest he offered the explanation that the management plan for Mr Yeeda comprised the letter back to Dr Todd stating that WA Cardiology essentially were unable to look after Mr Yeeda in Derby because they were no longer operating in the Kimberley Region. This is not a typical example of a management plan for a patient.[88]

**144.** Professor Judkins' view on there being no Wait List was predicated upon the assumption that the patients that had been referred to WA Cardiology were successfully discharged back into the care of the referring GP's. However, the West Kimberley Regional Prison's Health Services did not consider that WA Cardiology had discharged Mr Yeeda back into its care. An analysis of how other health services interpreted the arrangements is beyond the scope of the inquest.

**145.** I therefore accept the submission of the WACHS, through its lawyer the SSO, to the effect that it is not the case that WA Cardiology did not have a Wait List to hand over, whether it was to be referred to as a Wait List, or a list of patents referred to WA Cardiology under the MOU with WACHS-K, but not yet seen (or triaged, or requiring treatment).

**146.** The impact of the transition of cardiology services from WA Cardiology to Perth Cardiovascular Institute upon Mr Yeeda's cardiology referral specifically is outlined below.

## MR YEEDA'S CARDIOLOGY REFERRAL

**147.** Against the background of the failure to fully transition on the cardiology services, I turn now to address what occurred with Mr Yeeda's cardiology referral.

**148.** As outlined earlier, Mr Yeeda's EcHO records reflect that he was seen by the West Kimberley Regional Prison Medical Officer Dr Todd on 5 December 2017. On that date Dr Todd noted Mr Yeeda's history of rheumatic fever and left ventricular dilatation, and determined that he needed a cardiology review, and made a referral to the Visiting Cardiologist. The plan was for Dr Todd to review Mr Yeeda in three months' time. Two days later (7 December 2017) Mr Yeeda underwent

[88] Exhibit 2, tab 27; ts 87.

an ECG that was reviewed by Dr Todd and found by him to be "*abnormal*".[89]

**149.** Dr Todd's follow up review for Mr Yeeda occurred before the expiration of the planned three months. Dr Todd next saw Mr Yeeda for a cardiac check up on 25 January 2018. For reasons that are addressed below under this heading, the referral that Dr Todd made on 5 December 2017 was not progressed. Dr Todd had earlier formed the impression that Mr Yeeda was going to be seen by the Visiting Cardiologist before Christmas 2017.[90]

**150.** Therefore, on 25 January 2018, Dr Todd made, or commenced, another referral for Mr Yeeda to be seen by the Visiting Cardiologist. However, again for reasons that are addressed below under this heading, this referral was not progressed either. Dr Todd did not see Mr Yeeda for a medical consult again, prior to Mr Yeeda's death.[91]

**151.** Dr Todd had planned to see Mr Yeeda again in six months' time (after the 25 January 2018 consult). However, Dr Todd also testified that, essentially as a matter of practice, he would also tell his patients that if anything were to change, they should come back to see him before the next scheduled time. In a patient such as Mr Yeeda, it was Dr Todd's expectation that any shortness of breath would have generated an earlier appointment.[92]

**152.** At the inquest, the process of making the cardiology referral for Mr Yeeda was investigated.

**153.** Dr Todd made one complete cardiology referral for Mr Yeeda that was sent to WA Cardiology and Derby Hospital and he made or commenced a second cardiology referral. As outlined above, neither referral was progressed:

**a)** The first was a referral was directed to Derby Hospital for "*Cardiology + Echo*" signed by Dr Todd and dated 5 December 2017, with an endorsement indicating it was emailed on 6 December 2017; this referral notes Mr Yeeda's current clinical condition and includes reference to rheumatic fever with severe dilatation of left ventricle and moderate regurgitation of aortic valve; the priority rating is marked "*URGENT (Within 30 days)*; the

[89] Exhibit 2, tabs 11 and 12; ts 149 to 150.
[90] Exhibit 2, tab 12; ts 152 to 155.
[91] Exhibit 2, tab 12; ts 159 to 161.
[92] Ibid.

referral is on a Department of Justice Patient Referral Form, and appears to also have been emailed to WA Cardiology by the medical receptionist at West Kimberley Regional Prison; a further copy appears also to have been sent by Derby Hospital to WA Cardiology; Derby Hospital also filed a copy in Mr Yeeda's patient record at Derby Hospital; I refer to this in the remainder of this finding as the First Referral;[93]

**b)** Dr Todd was then informed by letter from WA Cardiology of the transition of service and he commenced or made a second referral to Derby Hospital for "*Cardiology and Echo*" dated 25 January 2018, which includes reference to the same current conditions; again it is on a Department of Justice Patient Referral Form ; the copy made available to the court from the prison clinical records is unsigned and there is no endorsement to indicate that it has been emailed or otherwise sent; I refer to this in the remainder of this finding as the Second Referral.[94]

**154.** I am satisfied that when Dr Todd made the First Referral, it was directed to Derby Hospital, and was sent to both WA Cardiology and to Derby Hospital (the latter then also onforwarding it to WA Cardiology). WA Cardiology received the First Referral and may have done so twice through separate means as outlined above.[95]

**155.** When it comes to the Second Referral it is noteworthy that it does not include the name of any hospital, that field is left blank. Nor is there a notation of a priority rating. These aspects, together with a lack of a signature, and no endorsement of it being sent make up the primary differences between the First Referral and the Second Referral.

**156.** It is clear the Second Referral was commenced by Dr Todd. The question arises as to whether the Second Referral was completed by Dr Todd and sent out for an appointment to be made with the Visiting Cardiologist. Being January 2018, this would have been the Visiting Cardiologist from Perth Cardiovascular Institute.

**157.** At the inquest, Dr Todd testified that he recalled printing out the Second Referral, filling it in and signing it, but was unable to offer an explanation as to why the completed and signed copy cannot be located. In the ordinary course it would have been printed out, filled in, signed

[93] Exhibit 2, tabs 10A and 27; ts 31; ts 93.
[94] Exhibit 2, tab 10.
[95] ts 13; ts 76.

and placed in the in box for the medical receptionist to fax it to the addressee.[96]

**158.** In the course of considering this question, the West Kimberley Regional Prison medical centre's usual process for sending out specialist referrals was considered, and evidence taken from the Clinical Nurse Manager at the material time.

**159.** The Clinical Nurse Manager informed the court that in her experience, referrals would be completed by the treating doctor and sent out by the medical receptionist. The Clinical Nurse Manger managed the nursing staff at the West Kimberley Regional Prison medical centre at the material time. Whilst she did not have oversight or any involvement with referrals for specialist treatment, she was able to give evidence concerning the process.[97]

**160.** The Clinical Nurse Manager provided the court with the excel spreadsheet entry that comprised the extract from the referral register of the West Kimberley Regional Prison medical centre, for Mr Yeeda. The details were ordinarily entered onto the register by the administrative staff members.[98]

**161.** The extract from the referral register records the First Referral for Mr Yeeda, for cardiology, with a comment that it relates to rheumatic fever, and an entry to the effect that it was emailed on 6 December 2017.[99]

**162.** However, the same extract from the referral register does not contain an entry for the Second Referral for Mr Yeeda. There are no other entries relating to Mr Yeeda in the referral register, and it is clear that information should not ordinarily be deleted from the register.[100]

**163.** The Clinical Nurse Manager's evidence was that the register was primarily devised so that the staff could follow up on reports from the treating specialists. It was also of assistance for ascertaining whether prisoners had had their specialist appointments, or whether they had been waiting a long time. In her experience, a five-month wait was not uncommon for specialist referrals.[101]

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[96] ts 152 to 155.
[97] Exhibit 1, tab 34.
[98] Exhibit 1, tab 34; ts 184 to 185.
[99] Ibid.
[100] Exhibit 1, tab 34;
[101] Ibid.

**164.** The oral evidence at the inquest, and the information on the referral register goes to show that the Second Referral was commenced, but not completed to the point of being sent out to Derby Hospital, or to Perth Cardiovascular Institute, or any other provider of cardiology services. Having regard to all of the evidence I am satisfied that the Second Referral was commenced by Dr Todd, it may have been made (that is, filled out and signed) by Dr Todd, but it was not sent out for the attention of the Visiting Cardiologist.

**165.** This raised the question of the impact of the advice to Dr Todd of the change in the cardiology service providers, and how that affected his understanding of the progression of First Referral, and why he commenced or made the Second Referral.

**166.** WA Cardiology wrote to Dr Todd at the West Kimberley Regional Prison by letter dated 9 January 2018 and they addressed the following:

**a)** acknowledged that Mr Yeeda had been referred to WA Cardiology for a consultation;

**b)** confirmed that as from 1 January 2018 Perth Cardiovascular Institute would be providing consultation services every two months to WACHS patients in Derby;

**c)** added that WA Cardiology would no longer be providing consultation services in Derby, but will be significantly increasing the frequency of their cardiology services in Broome;

**d)** referred to continuity of care and indicated they would be happy to look after Mr Yeeda in a timelier manner in Broome; and

**e)** noted that patients who wish to be seen locally should be re-referred to the new service (being Perth Cardiovascular Institute).[102]

**167.** In respect of the above letter, the Clinical Nurse Manager at the West Kimberley Regional Prison reported to the coroner that she recalled receiving some correspondence from WA Cardiology that she described as "*ambiguously worded*". Overall, she understood it to mean that WA Cardiology would no longer be providing services at Derby Hospital, but that they could still send prisoners to be seen by WA Cardiology in Broome.[103]

**168.** In the case of prisoners at the West Kimberley Regional Prison it was neither practical nor feasible to convey them to Broome or Perth, in

[102] Exhibit 1, tab 37.
[103] Exhibit 1, tabs 34 and 37; ts 188.

circumstances where there was a new Visiting Cardiologist there in Derby.

**169.** Considering the risk to patient health and safety that would arise from a misreading of that 9 January letter 2018 letter, it could have been worded better by WA Cardiology.

**170.** When the Clinical Nurse Manager read the letter from WA Cardiology dated 9 January 2018, she formed the view that the prisoners that had been referred to WA Cardiology still had an active referral. It is now known that the First Referral was not treated in this way.[104]

**171.** There were varying views proffered by clinicians at the inquest as to the status of the First Referral. As outlined earlier in this finding, Dr Phillips was of the view that WACHS was ultimately responsible for the care of the patients on WA Cardiology's Wait List, and that includes Mr Yeeda who was on that Wait List (or on a list) by reason of the First Referral. I am satisfied this position is supported by the evidence.

**172.** The other clinicians' views as to the status of the First Referral are outlined below.

**173.** Dr Joy Rowland (Dr Rowland), Director of Medical Services, Health Services, Department of Justice, drew attention to the fact that the First Referral had also been sent to Derby Hospital, and that health services are provided to the Department of Justice through the Department of Health. This is correct and in this case as described earlier in this finding WACHS-K contracted with external specialists for the provision of this service.[105]

**174.** In Dr Rowland's opinion, whilst there was a change in the service provider, the First Referral should still have been valid. Dr Rowland's expectation was that if a referral has been sent to WACHS then WACHS will provide the Department of Justice with a service. In Dr Rowland's opinion, the First Referral should have been known about, and an appointment offered to Mr Yeeda. If there was no local service available, the Department of Justice ought to have been alerted, and another service ought to have been organised (this may have included transfer or referral to a Perth service, if a cardiologist had triaged the First Referral and determined that Mr Yeeda needed to be seen within one month).[106]

[104] Exhibit 1, tabs 34 and 37.
[105] ts 194.
[106] ts 194 to 195.

**175.** In other words, Dr Rowland considered that, leaving aside the role of WA Cardiology, given that Derby Hospital had the First Referral, WACHS-K should have ensured that it was actioned (be it through the old provider or the new provider). Dr Rowland's position is consistent with that of Dr Phillips, to the extent of WACHS being ultimately responsible for Mr Yeeda's care.

**176.** Dr Rowland's attention was drawn to the manner in which the outstanding referral should have been recorded on Mr Yeeda's EcHO records.

**177.** Dr Rowland's expectation was that under the heading *Problem List* in Mr Yeeda's EcHO records, an entry should have been made in the section entitled *Diagnosis* or next to the words *Rheumatic Heart Disease*, to the effect that he had been "*referred*". In that way staff members who opened his file would have known there was an active referral. It would enable the staff members reviewing him to identify a gap and if appropriate, consider an alternative pathway to access specialist care.[107]

**178.** Through its lawyer the SSO, the Department of Justice accepts that the referrals (First Referral and/or Second Referral) ought to have been added to the *Problem List* in Mr Yeeda's EcHO records. The steps being undertaken by Department of Justice to rectify and/or reduce this risk are outlined under the heading *Improvements: Department of Justice* later in this finding.

**179.** On the question of the status of the First Referral, Professor Judkins' evidence was that at the expiration of the MOU, WA Cardiology no longer had a role in respect of it.

**180.** Professor Judkins posited that at the time of the receipt of the First Referral for Mr Yeeda, WA Cardiology was aware that it would no longer be providing cardiology and echocardiography services to WACHS-K as from 1 January 2018. Consequently, the 9 January 2018 letter was sent to Dr Todd.[108]

**181.** Professor Judkins acknowledged that it was unlikely that Mr Yeeda would be transferred from Derby to Broome for review by WA Cardiology's Visiting Cardiologist, and this can be accepted. He posited that WA Cardiology's expectation was that Dr Todd would make a new

[107] ts 195; ts 214.
[108] Exhibit 2, tab 27.

referral for Mr Yeeda, to Perth Cardiovascular Institute's Visiting Cardiologist, in Derby.[109]

**182.** Professor Judkins' view was that following that 9 January 2018 letter to Dr Todd, WA Cardiology considered that it had discharged Mr Yeeda back into the care of Dr Todd (for re-referral to Perth Cardiovascular Institute). On this characterisation, the First Referral was no longer valid, and would not be actioned by any person. I am not satisfied that the First Referral was in effect, made void through this process.[110]

**183.** Dr Todd's understanding as to the import of WA Cardiology's letter to him of 9 January 2018 was relevant to the inquest.

**184.** Dr Todd recalled that he saw this letter in January 2018, close to the time that he saw Mr Yeeda again. Dr Todd expressed his disappointment about the process accompanying this letter and felt that WACHS would have known there would be a change in provider several months before that letter was sent to him. As a consequence of the advice in this letter, Dr Todd testified that he re-referred Mr Yeeda when he next saw him, being 25 January 2018.[111]

**185.** At the inquest Dr Todd was shown the Second Referral, and his attention was drawn to the fact that it appeared to be incomplete. Dr Todd agreed and posited that he may not have been able to effectively save the document on the computer. He did however maintain that he made the Second Referral, and that he believed it would have again been forwarded to Derby Hospital.[112]

**186.** I am satisfied that Dr Todd ought to have been able to place reliance upon the fact that he had completed the First Referral on the appropriate form, which was sent to Derby Hospital and WA Cardiology. The request for an "*Echo*", being an echocardiogram, could potentially have been actioned without the presence of the Visiting Cardiologist, because at the material time WA Cardiology employed a local sonographer.[113]

**187.** I accept that Dr Todd printed out the Second Referral and that his intention was that it be progressed, by being completed and sent out to Derby Hospital and the new provider Perth Cardiovascular Institute. However, there is no evidence that the Second Referral was sent out by the medical receptionist at the West Kimberley Regional Prison.

[109] Exhibit 2, tab 27; ts 36 to 39; ts 84.
[110] Ibid.
[111] ts 128 to 130.
[112] ts 131 to 133.
[113] ts 13.

**188.** At the inquest Dr Rowland explained that the Second Referral was a printed copy of what was saved in Mr Yeeda's EcHO records, and even though the word "*Derby*" was not entered in the field for Hospital, it was on a regional referral form and in the ordinary course the medical receptionist would have sent it to Derby Hospital. Dr Rowland posited that the Second Referral must have become lost. That is the most likely explanation, and there is insufficient information before me, for me to make any finding as to the point at which it became lost.[114]

**189.** At the inquest Professor Judkins was confident that the First Referral would have been reviewed by cardiologist from WA Cardiology. Regrettably however WA Cardiology did not retain the record of which cardiologist triaged the First Referral (or its outcome). Professor Judkins explained that those patient management forms were not generally retained, and that they were used for guiding the process for booking the patient. This is an unfortunate practice, and a case such as this one demonstrates the importance of keeping medical records, including such patient management forms.

**190.** Professor Judkins posited that the First Referral was reviewed by WA Cardiology and was deemed not to require urgent discussion with the referring doctor. However, this cannot now be known because the patient management form was not retained. In terms of not having a process in place for keeping the patient management forms, Professor Judkins referred to it as an oversight on WA Cardiology's behalf.[115]

**191.** The evident problem is that there is no actual record of a cardiologist from WA Cardiology having triaged the First Referral, and importantly, if that triage had occurred, there has been no communication back to Dr Todd as to the outcome of that triage. If it was so triaged, it was not helpful for WA Cardiology to have kept the outcome of that triage to itself.

**192.** After the death the Director of Health Services for the Department of Justice sought a review of Mr Yeeda's health care while he was in prison.

**193.** In September 2020 the WACHS District Medical Officer Dr Cherelle Fitzclarence (Dr Fitzclarence) reviewed Mr Yeeda's medical records and reported on his medical management in prison. [116]

[114] ts 198; ts 207.
[115] ts 74 to 79.
[116] Exhibit 1, tab 38.

**194.** As part of that review Dr Fitzclarence considered the confusion over the referral. Dr Fitzclarence opined that there was confusion at Derby Hospital over whether WA Cardiology was actioning referrals or whether the new service provided by Perth Cardiovascular Institute was responsible. In her opinion this contributed to there being no cardiology appointment offered to Mr Yeeda prior to his collapse and death.[117]

**195.** Shortly after Mr Yeeda's death this potential for confusion appears to have been acknowledged. On 21 May 2018, clinicians from the prison, the Regional Medical Director for the Kimberley Region, the WACHS-K Specialist Coordinator and the Kimberley coordinator for the Perth Cardiovascular Institute met in an attempt to solve the issues with the cardiology referrals for future cases.

## EVENTS LEADING TO DEATH

**196.** Mr Yeeda died suddenly in the late afternoon on 3 May 2018 after playing some basketball at the West Kimberley Regional Prison. CPR was performed but he was unable to be revived. To those around him, his death may have appeared unexpected. However, when the extent of his cardiac disease is known and understood, his death was, from a clinical perspective, very sadly not unexpected.

**197.** The expert witness Professor Celermajer explained that Mr Yeeda's faulty aortic valve permitted oxygenated blood to flow back into his left ventricle after it had been pumped out of the heart into the aorta. This substantially increased the volume load on the left ventricle.[118]

**198.** Professor Celermajer further explained that with time, the dilated left ventricle can develop scarring and/or impaired blood supply to the heart muscle. This series of events places the heart at risk of arrhythmia, a potentially fatal disorder of electrical conduction of the heart. This risk is likely highest at times of sudden cardiac stress, such as during or just after exercise.[119]

**199.** In the few days prior to Mr Yeeda's death a relative and another prisoner observed that he had not seemed himself. Mr Yeeda appears to have experienced a nose bleed the night before his death. He told another prisoner that he had chest pain but that he was alright.[120]

[117] Exhibit 1, tab 38.
[118] Exhibit 1, tab 39.
[119] Ibid.
[120] Exhibit 2, tabs 11 and 12.

**200.** On the afternoon of 3 May 2018, Mr Yeeda and some other prisoners played cards, and he did not appear unwell. Following a head count, at approximately 2.30 pm Mr Yeeda went to the basketball area to "*shoot some hoops*" with some other prisoners. After this Mr Yeeda was observed walking with his hands on his hips and again did not look like himself. He did not reply when a relative asked if he was OK. He later collapsed, shortly after 4.00 pm that day.[121]

**201.** Specifically, Mr Yeeda's collapse occurred at 4.06 pm. He was not seen by anyone until 4.17 pm when another prisoner came across him and raised the alarm. Custodial officers arrived promptly after the alarm was raised, and CPR commenced at 4.20 pm. Resuscitation efforts took place continuously over a period of approximately one hour and involved the efforts of custodial officers, prison nurses, Dr Todd, ambulance officers and clinicians at Derby Hospital.

**202.** At the inquest, there were questions raised about the timing of the sequence of events surrounding Mr Yeeda's collapse, the initiation of CPR, the arrival of the ambulance officers, and the departure to the hospital. Having regard to all the evidence before me I am satisfied that the sequence of events as relayed by witnesses, and/or captured on the CCTV security cameras is as follows, with such times being of necessity approximate:

**a)** At 4.00 pm Mr Yeeda was seen to be walking towards the shower area, carrying a towel; he did not appear to be in any distress.

**b)** At 4.06 pm Mr Yeeda collapsed onto the ground; he attempted to get up but was unable to do so; there are detectable small movements in his body, and the CCTV vision reflects that after two minutes (after 4.08 pm) there are no further movements; no other person was present.

**c)** At 4.17 pm Mr Yeeda was found lying on the ground and unresponsive by another prisoner who ran to get help; a Code Red Medical Emergency was called shortly afterwards, between 4.22 pm and 4.25 pm.[122]

**d)** Meanwhile at 4.18 pm custodial officers arrived to assess Mr Yeeda and at 4.20 pm they commenced CPR; shortly afterwards the prison nurses (including the Clinical Nurse Manager) arrived to assist with the resuscitation efforts. Attempts were made to clear Mr Yeeda's

[121] Exhibit 2, tabs 8, 11 and 12.
[122] Exhibit 1, tabs 3 and 15.

airway. At 4.24 pm defibrillation and monitoring pads were attached and no shockable rhythm was found.[123]

**e)** Dr Todd's clinical shift had ended at 4.00 pm, and he was at the Prison Gate ready to leave when he heard the Code Red Medical Emergency (between 4.22 pm and 4.25 pm). He promptly turned back and was accompanied to the scene (as required). Upon arrival Dr Todd assisted with the resuscitation efforts and inserted an oropharyngeal airway; CPR continued with the team of custodial officers and nurses rotating, maintaining breaths and compressions.[124]

**f)** At 4.38 pm the ambulance officers arrived at West Kimberley Regional Prison and shortly afterwards they took over the resuscitation efforts; intravenous access could not be established and as a result adrenaline was given intramuscularly.[125]

**g)** At 4.44 pm, Mr Yeeda was transferred onto the ambulance trolley CPR continued. The ambulance departed at 4.55 pm, with Dr Todd and a prison officer on board accompanying Mr Yeeda and assisting with CPR efforts.[126]

**h)** Mr Yeeda was conveyed to Derby Hospital Emergency Department arriving at 5.10 pm with CPR in progress; he was intubated, and CPR continued at Derby Hospital, with the continued assistance of the custodial officers. Mr Yeeda's cardiac rhythm remained in asystole throughout. At 5.26 pm resuscitation efforts were ceased and Mr Yeeda was tragically pronounced dead.[127]

## CAUSE AND MANNER OF DEATH

**203.** The forensic pathologist Dr G. A. Cadden (Dr Cadden) made a post mortem examination on the body of Mr Yeeda at the State Mortuary on 10 May 2018. In his report to the coroner Dr Cadden noted Mr Yeeda's long standing history of cardiac disease. In his opinion, given the severity of Mr Yeeda's cardiac disease, sudden death would appear to have been a well recognised possibility, especially if there was an arrhythmic event.[128]

[123] Exhibit 1, tabs 8, 9, 15, 15E, 15H, 20 and 34.
[124] Exhibit 1, tabs 14, 15D and 16.
[125] Exhibit 1, tabs 15D, 15F, 15J, 15M, 21 and 22.
[126] Exhibit 1, tabs 15E, 15F, 16, 21 and 22.
[127] Exhibit 1, tabs 5, 14, 15L, 15N and 18.
[128] Exhibit 1, tab 6.

**204.** Toxicological analysis became available on 11 May 2018, and no alcohol or common drugs were detected.[129]

**205.** On 10 May 2018 the forensic pathologist formed an opinion on the cause of death. I accept and adopt the forensic pathologist's opinion. **I find that the cause of Mr Yeeda's death was rheumatic heart disease (severe aortic valve regurgitation).**

**206.** Professor Celermajer reviewed the information about the events leading to Mr Yeeda's death. In his opinion, and based upon the description of Mr Yeeda's collapse, he considers the death to be consistent with a sudden cardiac death brought on by vigorous exercise, against a background of his pre-existing severe aortic valve regurgitation and left ventricular dilatation.[130]

**207.** There is insufficient evidence for me to determine how vigorous Mr Yeeda's basketball exercise was on the afternoon of 3 May 2018. I am satisfied that the two events are not entirely unconnected. In other words, the basketball exercise is likely to have made some contribution to his sudden cardiac death.

**208.** It is not possible to quantify the contribution, nor is it possible to characterise it as a precipitating factor. Having regard to the severity of Mr Yeeda's pre-existing cardiac disease, the likelihood of sudden death without the contribution of vigorous exercise was very high.

**209. I find that the manner of Mr Yeeda's death was by way of natural causes.**

## WAS MR YEEDA'S DEATH PREVENTABLE

**210.** In considering what comments to make regarding the quality of Mr Yeeda's supervision, treatment and care it was necessary to first explore whether Mr Yeeda's death was preventable.

**211.** This entailed an inquiry into the likely outcome had Mr Yeeda's cardiology referral been progressed, and what the Visiting Cardiologist is likely to have recommended. It is to be recognised that this is based upon the following assumptions:

[129] Exhibit 1, tab 7.
[130] Exhibit 1, tab 39.

**a)** that Mr Yeeda would have attended the scheduled appointment with the Visiting Cardiologist; and

**b)** that Mr Yeeda would have accepted the recommendations of the Visiting Cardiologist and acted upon them.

**212.** At the inquest concerns were also expressed about the following:

**a)** that there was no Alert for custodial officers to warn Mr Yeeda against playing sport; and

**b)** that Mr Yeeda remained collapsed on the ground, unresponsive, for just over 10 minutes before he was sighted by any person.

**213.** For the reasons outlined in the next part of this finding, I am satisfied that:

**a)** It is likely that Mr Yeeda's death would have been prevented if he had undergone heart valve replacement surgery; although that surgery carried some degree of risk, there was a far greater risk for Mr Yeeda in not having the surgery;

**b)** It would have been appropriate for an Alert to have remained for Mr Yeeda not to have played sport; and

**c)** The delay in the commencement of the CPR is not attributable to any breach of procedures and did not contribute to Mr Yeeda's death.

## The likely outcome if Mr Yeeda's cardiology referral had been progressed

**214.** As outlined earlier, in this finding the reference to progressing Mr Yeeda's cardiology referral is a reference to arranging an appointment for Mr Yeeda with the Visiting Cardiologist. This should have been done by progressing the First Referral, despite the fact that Dr Todd went on to commence or make the Second Referral.

**215.** Numerous opportunities were missed, when it came to ensuring that Mr Yeeda was offered a cardiology appointment with the Visiting Cardiologist. He urgently needed such an appointment, and it may have saved his life.

**216.** There was in fact a cardiology clinic at Derby Hospital between 4 and 8 December 2017 but it was fully booked, and the priority rating given

by Dr Todd on Mr Yeeda's First Referral required that he be seen within 30 days. WA Cardiology were finishing up as service provider on 31 December 2017. Professor Judkins noted that WA Cardiology were flexible with their clinics, given that usually, a number of booked patients did not attend. He suggested that a call from the referring doctor may have prompted an appointment. However, that is speculation. [131]

**217.** If the usual process was followed, the First Referral would have been registered by WA Cardiology within three days of receipt and be the subject of a triage process by a cardiologist from WA Cardiology within five working days of receipt. These timeframes were within the arrangements under the MOU with WACHS-K.

**218.** With Perth Cardiovascular Institute taking over the role as from the beginning of January 2018, the next cardiology clinic at Derby Hospital was due in early 2018, possibly January 2018. The appropriate outcome would have been for Mr Yeeda to have been seen by the Visiting Cardiologist from Perth Cardiovascular Institute at its first clinic in early 2018, within or close to the 30-day time frame selected by Dr Todd.

**219.** However, in order for this to happen, Perth Cardiovascular Institute needed to know that the First Referral had been made, and they were not informed of this. Self-evidently they should have been informed of this outstanding patient. If formalities were required in order to take over that First Referral, they should not ultimately have operated as a barrier to an appointment being made in the interests of Mr Yeeda's health and safety.

**220.** In Dr Phillips' view, had Mr Yeeda's First Referral been transitioned to Perth Cardiovascular Institute, it would have improved the chances of him having an echocardiogram done in a timely manner, so that an assessment could then be made of the severity of his heart valve disease.[132]

**221.** There were numerous opportunities to transition the First Referral. Missed opportunities were raised for consideration at the inquest. Dr Phillips agreed that the following persons or entities ought to have taken steps in respect of the First Referral. I have outlined them below, by reference to the propositions agreed to by the witness, and my determinations, as follows:

[131] Exhibit 2, tab 27; ts 14; ts 38 to 39.
[132] ts 14 to 15.

**a)** Dr Todd should have kept an eye out to ensure Mr Yeeda was eventually seen; I am satisfied that Dr Todd did keep an eye out, and that is why he commenced or made the Second Referral. Unfortunately, Dr Todd was not sufficiently supported by a computer tracking based referral system.

**b)** WACHS-K (or "*Health*") had an obligation to ensure that there was a sufficient handover during the transition of service from WA Cardiology to Perth Cardiovascular institute; I am satisfied that WACHS-K did have this obligation, and they did not take all reasonably available steps ensure there was a sufficient handover.

**c)** WACHS-K (or "*Health*") had an obligation to ensure Mr Yeeda was seen; I am satisfied that WACHS-K had an obligation to ensure that Mr Yeeda was offered a cardiology appointment with the Visiting Cardiologist.

**d)** WA Cardiology had an obligation to ensure a sufficient handover to Perth Cardiovascular Institute; in terms of general obligations concerning patient care and safety, I am satisfied that WA Cardiology did not take all reasonably available steps to ensure there was a sufficient handover.

**e)** Perth Cardiovascular Institute had an obligation to ensure they got sufficient information in order to become the new provider; I am satisfied that for their part, Perth Cardiovascular Institute did take all reasonable steps, but they were reliant upon being informed of the outstanding patients by WACHS-K, who were in turn reliant upon being informed of the same by WA Cardiology.[133]

**222.** I am satisfied that if the First Referral (or any referral) had been transitioned to Perth Cardiovascular Institute, in the normal course it would have been progressed and an appointment would have been made for Mr Yeeda to see the Visiting Cardiologist in or about January 2018.

## The priority rating on Mr Yeeda's cardiology referral

**223.** At the inquest Dr Todd was questioned about the priority rating that he selected on the First Referral. I heard evidence from Dr Todd on this point and from Dr Rowland and Professor Judkins, who provided their views, given their respective areas of expertise. References in this part to priority rating include references to an urgency rating.

**224.** On the First Referral, Dr Todd selected "*URGENT (Within 30 days)*" and not "*IMMEDIATE (Within 7 days)*". The question was posed as to

[133] ts 24 to 25.

whether Dr Todd should have selected "*IMMEDIATE (Within 7 days)*". Essentially Dr Todd's evidence was that he did not consider that Mr Yeeda was displaying signs of cardiac failure, and he stood by his priority rating.[134]

**225.** Dr Todd explained that signs and symptoms of cardiac failure would include shortness of breath upon exertion (as a major symptom), swelling of the ankles, increased pulse pressure in the neck, and later fluid on the chest. At the inquest he confirmed that he checked Mr Yeeda for such symptoms and found none.[135]

**226.** Dr Rowland gave evidence on this point and explained that the *"IMMEDIATE"* priority rating would be used in the case of a fracture, or the identification of a lump, requiring a fairly quick assessment, but not necessarily requiring a presentation to an Emergency Department.[136]

**227.** Professor Judkins reviewed Mr Yeeda's First Referral and was questioned about the priority rating. He did not consider there was information contained in the First Referral that caused him to think that Mr Yeeda was clinically unwell from his rheumatic heart disease. However, he did also note that the First Referral was largely based upon an echocardiogram and other information from 2015. It was his view that, with no new information about clinical deterioration, this would prompt either a telephone call from the reviewing cardiologist to the referring doctor, or an earlier review.[137]

**228.** Professor Judkins explained that the priority rating that appeared on the First Referral may be entirely adequate if there had been no clinical deterioration since 2015. The types of matters that would be indicative of clinical deterioration would relate to worsening symptoms with exertion (primarily shortness of breath, but sometimes with chest pain, dizziness or blackouts). Without new clinical information he was unable to ascertain any clinical deterioration, which would increase the urgency with which Mr Yeeda should have been seen. He described the First Referral as a "*fairly routine*" referral.[138]

**229.** It is important to avoid hindsight bias when considering the question of the appropriate priority rating on the First Referral. Hindsight bias refers to the tendency to assume, after an event, that past events are more foreseeable than they were at the material time.

[134] ts 125 to 127; ts 135.
[135] ts 146.
[136] ts 224.
[137] Exhibit 2, tab 27; ts 39; ts 79.
[138] ts 63; ts 71 to 73.

**230.** I am satisfied that, while it now appears that a rating on the First Referral of "*IMMEDIATE (Within 7 days)*" would have been more appropriate, there were no clinical indications for such a rating when Dr Todd examined Mr Yeeda on 5 December 2017, and further that Dr Todd checked appropriately for clinical indications that may have affected his priority rating.

## The likely outcome of a cardiology review

**231.** It was relevant for me to hear evidence on the likely outcome had Mr Yeeda attended an appointment with the Visiting Cardiologist, as ordered by Dr Todd in the First Referral, within or close to 30 days from the date of that referral.

**232.** Mr Yeeda had not seen a cardiologist for some years, despite appointments being made for him. On some occasions he elected not to attend, on others he was unable to attend.

**233.** The last time Mr Yeeda had seen a cardiologist was at the Ord Valley Aboriginal Health Service in Kununurra on 17 April 2015. On that occasion he was reviewed by Dr James Ramsay, Paediatric Cardiologist, Child and Adolescent Health Services, based at Perth Children's Hospital. Dr Ramsay tried without success to engage Mr Yeeda in discussion about surgery. As outlined earlier in this finding, arrangements for surgery had been made for Mr Yeeda for March 2015 and March 2016, but those surgeries were cancelled due to there being no consent for them by or on behalf of Mr Yeeda.[139]

**234.** By December 2017/January 2018, Mr Yeeda urgently required a specialist cardiology review.

**235.** If Mr Yeeda been seen in January 2018 by the Visiting Cardiologist, it is highly likely that urgent heart valve replacement surgery would have been recommended for him. In reaching this conclusion, I have been assisted by the evidence of Dr Ramsay and Dr Celermajer who both have expertise in this area and addressed the question of Mr Yeeda's likely treatment plan, outlined in the parts below.

[139] Exhibit 2, tab 8B.

***The likely clinical examinations and investigations***

**236.** Dr Ramsay was asked about the likely clinical examinations and investigations if Mr Yeeda had seen the Visiting Cardiologist.

**237.** Dr Ramsay opined that in such a scenario Mr Yeeda would have undergone a full clinical history, clinical examination, and cardiac investigations. The clinical history would have been aimed at ascertaining whether he had cardiac symptoms, which may have included shortness of breath, chest pain at rest and/or with exercise and palpitations. His compliance with penicillin injections over the previous 12 to 18 months would have been considered.[140]

**238.** Mr Yeeda's clinical examination would have included pulse rate and rhythm, blood pressure, any clinical evidence of a large heart, respiratory rate at rest, assessment of any cardiac murmurs, any evidence of heart failure, and any evidence of pulmonary oedema due to left sided heart failure.[141]

**239.** Mr Yeeda's clinical investigations would have included an ECG (which can show evidence of a large left ventricle and also evidence of left sided heart strain), an echocardiogram (the main test to determine how the heart is functioning), possibly a 24-hour Holter Monitor or exercise test (depending on whether the echocardiogram shows heart dysfunction).[142]

**240.** An echocardiogram would have provided a range of relevant information, including evidence of the severity of Mr Yeeda's aortic valve regurgitation, and of any increase in the severity of aortic stenosis (narrowing of the aortic valve) related to scarring from rheumatic heart disease and/or valve repair, and the degree of mitral regurgitation. It would also confirm that his heart remained suitable for replacement of the aortic valve.[143]

**241.** In Dr Ramsay's opinion it was most likely that the Visiting Cardiologist would have identified a major issue with his aortic valve. There probably would have been more severe leaking of the valve and more narrowing of the valve.[144]

**242.** Professor Celermajer also referred to the extensive investigations that would have been undertaken had Mr Yeeda been seen by the Visiting

[140] Exhibit 2, tab 8D.
[141] Exhibit 2, tab 8D.
[142] Exhibit 2, tab 8D.
[143] Exhibit 2, tab 8D.
[144] ts 99.

Cardiologist in late 2017 or early 2018 and was in broad agreement with Dr Ramsay.[145]

### *The likely clinical advice*

**243.** Based upon what is already known of Mr Yeeda's cardiac status when he was last seen in 2015, Dr Ramsay opined that it is likely that there was an increase in the severity of the aortic valve regurgitation, and possibly an increase in the severity of the aortic stenosis, that would be causing increasing stress on the left ventricle.[146]

**244.** In Dr Ramsay's opinion:

**a)** If the heart function was decreased (but only mild to perhaps moderately so) then cardiac surgery would still have likely been the recommendation. In his experience this would usually involve the replacement of the aortic valve with a prosthetic metal valve; an ongoing issue post-surgery would be the need to take daily anticoagulation therapy to prevent thrombosis (clot) forming on the valves, and being compliant with the penicillin injections to prevent a recurrence of acute rheumatic fever;

**b)** Surgery might have involved the "*Ross Procedure*" which utilises the patient's own pulmonary valve, though he noted that it has not been used in many patients in Australia as the reported long-term risks are significant;

**c)** It may also have been necessary to replace the mitral valve (if the valve function had deteriorated significantly); very rarely the tricuspid valve may have to also be repaired or replaced; and

**d)** If there is severe heart dysfunction, the risks of surgery increase dramatically; the cardiologist would likely have presented the findings to a multidisciplinary team at the Tertiary Adult Cardiac Service (probably at Fiona Stanley Hospital).[147]

**245.** Professor Celermajer also considered, hypothetically, the advice that a cardiologist would have given to Mr Yeeda, as of December 2017 or early 2018, and he confirmed he would also have expected such advice to be given to Mr Yeeda in 2015 and 2016, before his surgeries were cancelled, as follows:

[145] ts 46 to 47.
[146] Exhibit 2, tab 8D.
[147] Exhibit 2, tab 8D.

> "*Mr Yeeda would have been told that his medical condition was such that his aortic valve needed to be replaced. He would have been told that if it was not replaced, it would have a major impact on his life and significantly reduce the length of his life expectancy. There would have been a risk of sudden cardiac death, likely markedly lessened by successful aortic valve replacement surgery*."[148]

**246.** In Professor Celermajer's opinion, there was a high degree of probability that sudden cardiac death would have been prevented if Mr Yeeda had undergone a procedure to replace his aortic valve at any time after he was identified in May 2014, or at least the risk would have been substantially reduced.[149]

**247.** I am satisfied that if Mr Yeeda had he been seen by the Visiting Cardiologist, he would have been advised to have surgery, and warned that without it, his life was likely to be at risk.

### *The prospects of surgery being successful*

**248.** Dr Ramsay addressed the post-operative mortality risk:

**a)** If the echocardiogram had not shown severe left ventricular dysfunction, then Mr Yeeda would have been offered surgery again; the risks would have been related to the severity of the heart dysfunction and also how many valves would have needed to be replaced, with the post-operative mortality risk at 30 days ranging from between approximately 2% and 7%;

**b)** If the echocardiogram had shown severe left ventricular dysfunction, the post-operative mortality risk at 30 days would be significantly increased.[150]

**249.** Professor Celermajer however believed that Dr Ramsay may have perhaps overstated the risk of there being more than one valve requiring replacement. In his opinion, having regard to Mr Yeeda's latest echocardiogram in November 2014, which made no mention of concern with another valve, by 2018 there was less than a 5% chance of an echocardiogram indicating a substantial concern with any valve other than the aortic valve.[151]

[148] Exhibit 1, tab 39; ts 53.
[149] Exhibit 1, tab 39; ts 47.
[150] Exhibit 2, tab 8D.
[151] Exhibit 1, tab 40.

**250.** Dr Ramsay outlined the risks of replacement with a mechanical valve. There are known ongoing risks with such surgeries including thromboembolic problems (strokes and thrombosis of the mechanical valve), the risk of reoperation for all valve surgery for rheumatic heart disease after 10 years, and a late mortality risk following cardiac surgery for aortic valve replacement of around 20% to 30% over five years.[152]

**251.** In Professor Celermajer's clinical opinion however, given Mr Yeeda's history, he would not have recommended a mechanical valve. A younger person (who may not be as diligent with medication compliance) would be offered a tissue replacement. An older person would more likely be offered a mechanical valve. Having regard to Mr Yeeda's history, he considered it would have been appropriate to offer to replace his aortic valve with a tissue valve. Under this scenario, the recipient is not required to take long term anticoagulation medication after surgery.[153]

**252.** Professor Celermajer outlined risks and benefits of replacement with a tissue valve. Whilst a tissue valve would not require regular anticoagulants, such valves usually degenerate between eight and 15 years. They can degenerate a little faster in people with repeated episodes of rheumatic fever.[154]

**253.** In Professor Celermajer's opinion, given that surgery for Mr Yeeda had been planned for March 2015 and March 2016, it is highly likely that his heart still would have been suitable in early 2018, for replacement of the aortic valve. He also considered that Mr Yeeda would have been told to avoid any form of vigorous exercise until he had heart valve replacement surgery and recovered from that surgery.[155]

**254.** Professor Celermajer considered that Mr Yeeda was still operable given that he was not complaining of breathlessness. He did not consider that Mr Yeeda also had dysfunction of the left ventricle, again citing the lack of breathlessness. He expressed significant concern about Mr Yeeda not having had heart valve replacement surgery already and described it as an urgent need.[156]

**255.** Professor Celermajer considered that the long-term benefits outweighed the short-term risks associated with the surgical procedure.[157]

[152] Exhibit 2, tab 8D.
[153] Exhibit 1, tab 39; ts 51.
[154] ts 51.
[155] Exhibit 1, tab 39.
[156] ts 52; ts 55.
[157] Exhibit 1, tab 40.

**256.** Professor Judkins agreed with Professor Celermajer that Mr Yeeda clearly needed valve surgery, and for that to happen, he needed a cardiology consultation.[158]

**257.** I am satisfied that the prospects of surgery being successful were good, that there was some risk to the surgery (which must be explained to the patient), but that the likely benefits outweighed the risk.

### *The likely benefits of surgery*

**258.** Professor Celermajer opined that if Mr Yeeda had undergone a procedure to replace his aortic valve at any time after he was identified in May 2014 as requiring such replacement, there is a reasonably high degree of probability that his death in May 2018 from sudden cardiac death would have been prevented, or at least the risk would have been substantially reduced. The replacement of the valve would have restored the competency of the valve, and it would also have immediately improved the volume loading and strain on the left ventricle.[159]

**259.** Professor Celermajer noted that Mr Yeeda was identified in 2014 as requiring replacement of his aortic valve. He reported to the coroner his opinion on mortality without that surgery: "*Mr Yeeda would have had somewhere between a 30% - 40% chance of dying from progressive heart failure or sudden cardiac death in the following 10 years, that is up until 2024. There is a very high mortality and morbidity rate, if one does not operate under these circumstances*".[160]

**260.** It is to be borne in mind that Mr Yeeda would have had to consent to such surgery, and it is known that past planned surgeries in 2015 and 2016 had been cancelled by or on his behalf. Professor Celermajer's evidence was to the effect that he did not minimise the challenge of getting a young adult to agree to a big medical procedure, given that teenagers and young adults do not want to contemplate unwellness or mortality. However, in his experience if the situation is laid out plainly and accurately, and the person feels supported and in a trusting relationship with the provider and the provider's team, the vast majority of young adults opt for surgery.[161]

**261.** Whilst it is not possible to know whether, if offered, Mr Yeeda would have consented to heart valve replacement surgery, I am satisfied that if

[158] ts 65.
[159] Exhibit 1, tab 39; ts 57.
[160] Exhibit 1, tab 40.
[161] ts 54.

undergone, such surgery properly performed would have restored the competency of the valve, and improved the strain on his left ventricle, with the result that his life would likely have been saved.

## The effect of vigorous exercise

**262.** Mr Yeeda's family were concerned to hear that he had been playing sport very shortly before his death, considering all their efforts (especially his grandmother's) to dissuade him from vigorous activity due to his heart condition. It was their expectation that the custodial officers would have actively discouraged sport. There was in fact a process for this to occur, but the process was not followed. The evidence given at the inquest on this aspect is outlined below.

### *The removal of the Alert: not fit for sport*

**263.** On 19 February 2018, when Mr Yeeda was given his monthly penicillin injection, one of the clinical nurses made a note on his EcHO records that he was: "*playing basketball which is great*". This was not in fact "*great*". This activity does not appear to have been authorised by Dr Todd, and at this stage there was still an Alert on Mr Yeeda's Total Offender Management records (TOMS records) to the effect that he was not fit for sport.[162]

**264.** In fact, since 18 May 2017, Mr Yeeda's medical status on his TOMS records carried an Alert to the effect that he was not fit for sport, and not fit for work, due to: "*heart condition*". This Alert remained in place until 12 April 2018 when, inexplicably, it was removed by the Clinical Nurse Manager at the West Kimberley Regional Prison. The Alert was un-checked, meaning that he now appeared as being fit for sport and fit for work. The reference to "*heart condition*" was deleted.[163]

**265.** Custodial staff do not have access to prisoner's EcHO records but they have access to medical information on the Medical Status module of the prisoners' TOMS records, which includes Alerts. The clinical staff are responsible for ensuring the Medical Status information is current and is entered into the system as soon as practicable.[164]

**266.** One of the purposes of an Alert on a prisoner's TOMS records is for custodial officers to be aware of health risks for prisoners, and to manage compliance to reduce health risks.

[162] Exhibit 2, tab 12; Exhibit 3, tab 29; ts 137 to 138.
[163] Exhibit 3, tab 29; ts 178 to 179.
[164] Exhibit 6.

**267.** At the inquest the Clinical Nurse Manager was questioned as to why she removed the Alert on 12 April 2018. She had no recollection as to the reason for the change she made on Mr Yeeda's TOMS records. The Clinical Nurse Manager also testified as to her normal practice for altering Alerts.[165]

**268.** The Clinical Nurse Manager explained that on occasion, custodial officers would contact her to request an assessment as to whether Alerts for prisoners were still valid. She clarified that in respect to fitness for work and fitness for sport, there are different levels, distinguishing in essence between light and heavy duties, and making similar comment in respect of sport participation. Her normal practice would have been to review the EcHO records before altering a health-related Alert.[166]

**269.** When the Clinical Nurse Manager altered the Alert for Mr Yeeda, she also removed the reference to "*heart condition*" in the comments box. She did not make a contemporaneous entry into Mr Yeeda's EcHO records and at the inquest she described this as her error, she should have done that, and that she did not have an excuse for it.[167]

**270.** In respect of the changes she made, the Clinical Nurse Manager posited that she would have seen the entry in Mr Yeeda's EcHO records of 19 February 2018 to the effect that he was already playing basketball and is likely to have taken that into account in making her change. It is also noted that Dr Todd's earlier entry of 5 December 2017 (the date of his First Referral) stated: "*doesn't play sport – grandmother forbade it*". The Clinical Nurse Manager may have taken this to mean that the family had forbidden the sport, and not the doctor. The Clinical Nurse Manager did not recall whether she spoke with Dr Todd before she made the changes that removed the Alert.[168]

**271.** The Clinical Nurse Manager ought to have spoken with Dr Todd before making the changes to the Alert for Mr Yeeda, especially as she removed the reference to "*heart condition*". At the inquest the Clinical Nurse Manager posited that her intent in deleting "*heart condition*" was not to dispute that condition, rather her likely aim was to allow Mr Yeeda to try and have as normal a life as possible, considering his rheumatic heart disease.[169]

[165] Exhibit 1, tab 35; ts 172 to 173; ts 260 to 261.
[166] ts 174; ts 181.
[167] Exhibit 2, tab 12; Exhibit 3, tabs 29 and 30; ts 174 to 175.
[168] Exhibit 2, tab 12; Exhibit 3, tabs 29 and 30; ts 174; ts 182.
[169] Exhibit 2, tab 12; Exhibit 3, tabs 29 and 30; ts 180; ts 253.

**272.** In her earlier report regarding the incident the Clinical Nurse Manager sought to explain her actions by stating, amongst other things, that she could only assume that she assessed that Mr Yeeda had rheumatic heart disease with no other ongoing issues and that this should not prevent him from attempting to live a normal life which would have included activities such as sport and light work.[170]

**273.** The Clinical Nurse Manager testified that, with the benefit of hindsight, she would not make such changes to an Alert in similar circumstances without speaking with the doctor, and she would also document her reasons for making the change in the prisoner's EcHO records.[171]

**274.** In terms of how the custodial officers should treat an Alert not to play sport, I heard evidence from the Superintendent of the West Kimberley Regional Prison at the material time, Douglas Coyne. Mr Coyne explained that if a nurse was aware that Mr Yeeda was playing basketball in February 2018, he would have expected the Prison Health Services to contact Mr Yeeda and speak with him and reinforce the information to him and to the unit custodial officers, that he was not to play sport. The custodial officers should discourage sport (with appropriate explanations), as opposed to prohibiting it.[172]

**275.** Dr Rowland assisted with giving evidence in this area at the inquest, from the Prison Health Services' perspective. She acknowledged that rheumatic heart disease is common in the Kimberley region. In her experience a lot of people with rheumatic heart disease have no problems playing sport. She noted that it feels punitive to tell someone they cannot play sport. However, in her view, in the case of Mr Yeeda, if his EcHO records had been reviewed there was adequate information in there to give pause. Dr Rowland agreed the Alert should not have been altered in the way that it was done by the Clinical Nurse Manager.[173]

**276.** At the inquest Dr Todd's evidence was that Mr Yeeda was aware he should not play sport, and that Dr Todd had reiterated that with him. Dr Todd would not have agreed to the removal of the Alert (against the playing of sport), and I accept that. Any removal of such an Alert should have been based upon the advice of the doctor. However, Dr Todd also felt that despite his efforts to provide explanations, Mr Yeeda lacked insight into the health implications of his rheumatic heart disease.[174]

[170] Exhibit 3, tab 30.
[171] ts 176.
[172] ts 265.
[173] ts 205; ts 210.
[174] ts 49; ts 132 to 139; ts 146 to 147.

**277.** It would appear that when Dr Todd opened up Mr Yeeda's EcHO records on 13 March 2018, in order to address the requirement for his penicillin injection, regrettably he did not read the nurse's prior notation of 19 February 2018 about Mr Yeeda playing basketball, otherwise he would have been concerned.[175]

**278.** The Department of Justice through its lawyer the SSO accepts that Mr Yeeda's Alert should not have been changed without further consultation. I am satisfied that the further consultation should have been with Dr Todd, and the likely outcome is that Dr Todd would have required the Alert to remain in place and that Mr Yeeda would have been discouraged from playing basketball, and informed of the risks of such activity.

### *The effect of exercise on Mr Yeeda's heart function*

**279.** Exercise can range from mild to vigorous, and even these terms will mean different things to different people. Nonetheless patients with cardiac disease do need advice in this area.

**280.** Having regard to Mr Yeeda's cardiac disease, he should not have engaged in vigorous exercise. He was a person held in care and he should have had clear advice and guidance on this point.

**281.** Dr Ramsay noted that since he last saw Mr Yeeda in 2015, there has been an increasing left ventricular strain pattern. In Dr Ramsay's opinion, this may have resulted in Mr Yeeda being at increased risk in the event of strenuous exercise. If he exercised in hot conditions then had a hot shower, this may have caused generalised vasodilation (dilatation of blood vessels). In combination with severe aortic valve regurgitation this could reduce the amount of blood flow to the heart.[176]

**282.** Along a similar vein, the expert witness Professor Celermajer opined that until Mr Yeeda's aortic valve had been replaced, he should have been told to avoid vigorous exercise. He agreed with the earlier nursing note made at Albany Regional Prison that he should not engage in sports or strenuous activity or work until he was medically reviewed. In his view, this should involve a review by a cardiologist before clearance could be given.[177]

[175] Exhibit 2, tab 12; ts 156 to 157.
[176] Exhibit 2, tab 8A.
[177] Exhibit 1, tab 39; ts 47.

**283.** In Professor Celermajer's experience the general recommendation for people with severe aortic valve regurgitation would be that they do not compete in vigorous or competitive sports. However, he cautioned that there is a lack of data surrounding such recommendations given that there are not many people in Australia in Mr Yeeda's position, who have not received a valve replacement.[178]

**284.** Professor Celermajer added that in all likelihood he would not have counselled Mr Yeeda against recreational sport, unless it was a hot day, and unless he was feeling poorly when doing that kind of exercise. His preference would have been to advise Mr Yeeda to undertake the activities of daily living and engage in gentle ambulatory exercise.[179]

**285.** Professor Celermajer was informed that within the hour preceding his collapse Mr Yeeda had been playing basketball with others. He explained that the cessation of exercise does not mark the end of the period of risk, and that with Mr Yeeda's condition, the risk is up to an hour afterwards.[180]

**286.** However, Professor Celermajer also considered that Mr Yeeda's pre-existing condition was such that he could have experienced a sudden cardiac arrest even without vigorous exercise.[181]

**287.** At the inquest Professor Judkins explained that the question of physical exercise is something that, as a cardiologist, he looks at quite frequently. It is part of the information he would give to patients awaiting surgery. In his experience in the situation of Mr Yeeda, he would have advised against vigorous physical activity. He would be concerned about any activity that, through the heat of the body, leads to vasodilation, because this would cause a problem with the valve.[182]

**288.** I accept that a diagnosis of rheumatic heart disease (with no further complications) does not necessarily mean that a person cannot engage in sport. I also accept there is a sound basis for normalising the prison environment and not being punitive in the area of sport. However, Mr Yeeda's condition was serious, he had severe aortic valve regurgitation, placing strain on his left ventricle.

**289.** I am satisfied that it would have been in Mr Yeeda's interests not to engage in the basketball exercise on the afternoon of 3 May 2018, as it

[178] ts 49.
[179] ts 52; ts 59.
[180] Exhibit 1, tab 39.
[181] Exhibit 1, tab 39.
[182] ts 65 to 66.

was likely to become vigorous. Some gentle ambulatory exercise would have been suitable. There was no guidance offered to him by the custodial officers on this point. Regrettably the Alert had been removed.

**290.** I have outlined earlier in this finding that the basketball exercise is likely to have made some contribution to Mr Yeeda's sudden cardiac death, though it is not possible to quantify the contribution, nor is it possible to characterise it as a precipitating factor.

### *Fitness for work duties*

**291.** Another issue arose, also related to the removal of the Alert, in relation to Mr Yeeda's fitness for work.

**292.** A relative of Mr Yeeda, who shared his room, was aware of his health condition, namely that he had a heart problem, that he had to have monthly injections, and that he took daily medication. This prisoner informed the court that in the couple of days before his death a custodial officer had instructed Mr Yeeda to do cleaning work at the prison, which prisoners generally were required to do. He informed the custodial officer that Mr Yeeda was sick, but on his observations, this did not change anything, in terms of him being required to do cleaning work.[183]

**293.** Mr Yeeda's family have expressed concerns about whether the custodial officers required him to do onerous work when he had a severe heart condition.

**294.** The Total Offender Management Records for Mr Yeeda as at the material time record him as a "*Unit Worker*".[184]

**295.** I do not consider the work duties to have required vigorous movement. However, it would have been appropriate for the Alert to have remained in place and for Mr Yeeda not to be required to undertake work duties unless and until specifically cleared by the doctor to do so.

## The delay in commencing CPR

**296.** CCTV footage shows that Mr Yeeda collapsed at 4.06 pm on 3 May 2018, and that eleven minutes elapsed from the time that Mr Yeeda collapsed until he was found by another prisoner. CPR commenced at 4.20 pm, 14 minutes after his collapse.

[183] Exhibit 1, tabs 12 and 13.
[184] Exhibit 1, tab 31.

**297.** When Dr Todd arrived at the scene, prison staff were performing CPR on Mr Yeeda. Dr Todd immediately noted that Mr Yeeda was tilted slightly to the left on the ground, with the result that when the custodial officers pushed down centrally, they pushed his chest wall into his stomach, which caused him to vomit.[185]

**298.** Dr Todd had this rectified and remained of the view that despite the slight tilt of Mr Yeeda's body, the CPR would still have been effectively performed. Given the time that elapsed before CPR was commenced, Dr Todd did not consider that the way CPR was being conducted would have changed the outcome.[186]

**299.** Records reflect that the officers who performed the CPR on Mr Yeeda were up to date with their training. Prison staff (including medical staff) are required to complete mandatory CPR refresher training every 12 months.[187]

**300.** At the inquest I heard evidence about the likely effect of the lapse of time before commencement of the CPR, upon Mr Yeeda.

**301.** Professor Celermajer, being informed of the circumstances, opined as follows: "*The eleven minutes Mr Yeeda lay there was an extremely long down time for his vital organs. I suspect after that period of time it would have been extremely unlikely that Mr Yeeda could have been saved*."[188]

**302.** Professor Celermajer explained that after more than five minutes of "*down time*", meaning no cardiac output, the chance of healthy neurological recovery is very low, even if heart recovery is achieved.[189]

**303.** At the inquest the question was raised as to whether, given the locations of the CCTV cameras, Mr Yeeda should have been found earlier by custodial officers. This would have required the custodial officers in the monitoring area to be tasked with scanning the various CCTV cameras at the West Kimberley Regional Prison for all areas on an ongoing basis throughout their shifts. They were not so tasked.

**304.** A primary function of the CCTV cameras is to monitor the perimeter, or areas where there may be an elevated risk regarding prisoner interactions

[185] ts 144; ts 165.
[186] ts 143; ts 167.
[187] Exhibit 1, tab 15R; Exhibit 3, tab 27.
[188] Exhibit 1, tab 39.
[189] ts 50.

(such as football matches). One of the aims at the West Kimberly Regional Prison is to attempt to make the prison environment similar to community life and this is not supported by constant monitoring, which may be experienced as intrusive.

**305.** The various CCTV cameras at the West Kimberley Regional Prison are not continually monitored for all areas all the time, and this is not their function. I do not make any adverse comment in connection with the time that it took to locate Mr Yeeda.

**306.** I am satisfied that the custodial officers and prison staff (including nursing staff and Dr Todd) all responded promptly when they were alerted to the emergency, that CPR was commenced as soon as it was reasonably possible and that it was performed assiduously to the best of the ability of all those present. Sadly, despite those efforts, the likelihood of Mr Yeeda being revived by that stage was minimal.[190]

## QUALITY OF SUPERVISION, TREATMENT AND CARE

**307.** Immediately before his death, Mr Yeeda was held in the care and custody of the CEO of the Department of Justice, in accordance with the *Prisons Act 1981*. Section 25(3) of the Act requires me to comment on the quality of the supervision, treatment and care of Mr Yeeda while in that care.

**308.** My comments are primarily made in connection with the medical care and treatment that Mr Yeeda received while in custody as an adult and are focussed upon the assessment and treatment of his rheumatic heart disease, the management plan and preventative care by:

**a)** the Department of Justice, in connection with the Prison Health Services at West Kimberley Regional Prison; and

**b)** the WACHS-K in connection with the provision of the specialist cardiology services to West Kimberley Regional Prison.

**309.** I have also commented on the role of WA Cardiology in connection with the transition of the Visiting Cardiology Service.

[190] ts 245.

## Department of Justice

**310.** Dr Rowland prepared a report for the coroner and gave evidence at the inquest concerning the Department of Justice's review of the medical management of Mr Yeeda. She also testified in respect of the report by WACHS District Medical Officer, Dr Fitzclarence.[191]

**311.** Dr Fitzclarence had reported to the coroner that in her opinion the health care that Mr Yeeda received while in the care of the Department of Justice was superior to that which he would have received in the community. The doctor pointed to a number of factors including the fact that staff had direct access to Mr Yeeda and they were not relying on him visiting a community clinic.[192]

**312.** Dr Fitzclarence drew attention to the extensive evidence that Mr Yeeda struggled to attend his appointments with health professionals when he was not incarcerated and was not adherent to his recommended regime of monthly penicillin injections. The doctor questioned whether this would have continued once he was released and felt it would be hard to know.[193]

**313.** Dr Rowland initially concurred with Dr Fitzclarence's views and considered that the medical treatment and care that Mr Yeeda received in custody was better than had been "*achieved*" for him in the community in the nine months prior to him arriving in custody.[194]

**314.** However, in considering the quality of medical treatment and care offered to Mr Yeeda while he was in custody, I do not take account of whether he would have availed himself of medical care, agreed to attend medical appointments and/or agreed to surgery, based upon assumptions drawn from his past lack of engagement with health services in the community. The critical issue is whether an appropriate level of medical care and treatment was offered in custody and, if consented to, arranged for him.

**315.** The fact that Mr Yeeda may have declined to attend specialist medical appointments in the community, declined past surgeries and/or declined his monthly penicillin injections in the community, does not lower the bar for the level of medical treatment and care that he was to be offered in custody.

[191] Exhibit 1, tab 41; ts 189 to 228.
[192] Exhibit 1, tab 38.
[193] Ibid.
[194] ts 193.

**316.** It is important for clinicians to look for the right communication when a person in Mr Yeeda's position, so obviously in need of surgery, appears to decline surgery. It is important not to assume that such a person will continue to decline treatment into the future. With increasing maturity, and possibly a greater level of comfort after being transferred to the Kimberley Region, it is noteworthy that in December 2017 Mr Yeeda agreed to see the Visiting Cardiologist.

**317.** In connection with the quality of treatment and care, I will deal first with the administration of Mr Yeeda's penicillin injections in custody. These were assiduously administered, for the very important purpose of preventing a recurrence of rheumatic fever and avoiding further damage to his heart. Self-evidently the clinicians were able to encourage Mr Yeeda to have the injections on a regular basis. In this area, the Department of Justice provided a high level of treatment and care and the position expressed by Dr Rowland is supported.[195]

**318.** However, the situation is quite different when it comes to the quality of Mr Yeeda's treatment and care with respect to his rheumatic heart disease, and the need for him to be urgently reviewed by the Visiting Cardiologist.

**319.** I have taken account of Professor Celermajer's view to the effect that Mr Yeeda's medical need to see a cardiologist was not met whilst he was in the care of the prison medical service. He explained that Mr Yeeda was identified in 2014 as requiring a replacement of his aortic valve. Further that at no time during the last five months of Mr Yeeda's life was the Prison Health Service able to arrange for Mr Yeeda to be seen by a cardiologist.[196]

**320.** At the inquest Professor Celermajer confirmed he disagreed with Mr Yeeda's care being superior to what he would have received in the community, given that essentially he was not seen by a cardiologist. I accept Professor Celermajer's opinion on this point.[197]

**321.** Dr Rowland was questioned about the Department of Justice's responsibilities in the context of the treatment and care of Mr Yeeda's rheumatic heart disease. Dr Rowland informed the inquest that, after a referral (to a specialist) is made, the Department of Justice's obligations are to ensure that the patient remains safe whilst that referral is pending. This includes adequate review and monitoring of the patient's status in

[195] Ibid.
[196] Exhibit 1, tab 40.
[197] ts 48.

the event that the situation changes, and the urgency of the referral needs to be revisited.[198]

**322.** Dr Rowland outlined that if a patient is on a list (to be seen by a specialist), there is an obligation to be aware that they are on the list and advocate for them if necessary, for example if there is a "*blockage*". There is also an obligation to ensure continuity of care, if a patient is transferred or discharged while a referral is pending.[199]

**323.** In respect to the obligations of the Department of Justice, at the inquest Dr Rowlands' evidence was that:

**a)** exercise was likely to have been a trigger, given it can alter the haemodynamics and place stress on the heart;

**b)** the Department of Justice failed to monitor the referral (be it the First Referral of the Second Referral) and pick up that Mr Yeeda had not been seen in time; and

**c)** as a result the Department of Justice, Health Services, was unable to advocate on Mr Yeeda's behalf.[200]

**324.** Dr Rowland conceded that there cannot have been adequate systems in place in 2018 because essentially the lack of progression of the referral for Mr Yeeda (be it the First Referral of the Second Referral) was not noticed and it failed. On the question of the responsibility for ensuring the progression of the referral, Dr Rowland characterised it as a systemic issue:

> "*....in terms of if we're trying to solve a problem about referrals and tracking, do we put the onus of that responsibility onto your doctor when you've got limited doctor time and they're your most expensive resource on site and you do not need a medical degree and postgraduate training in order to track something like referrals or do you need a – a process that actually involves a team and maybe adequate qualifications to track and chase up referrals rather than placing the whole onus on the practitioner who's also dealing with all the others. And there are many referrals, particularly where – there is a very high burden of chronic disease in the Kimberley and there's a very high burden of chronic disease inside Derby Prison. And if we wanted Dr Todd to be responsible for tracking and checking the status of all of those referrals for all of those patients, that's going to have a significant impact on his clinical time to actually talk to people. So should Dr Todd have done all that? I think the system – it should have been adequate systems in place.*"[201]

[198] ts 194.
[199] Ibid.
[200] ts 216.
[201] ts 199.

**325.** I accept Dr Rowland's evidence on this point and I am satisfied that the systems were not in place to support Dr Todd in the progression of the referral that he had made for Mr Yeeda (be it the First Referral and the Second Referral). I also accept the submission of the SSO and am satisfied that it is not entirely reasonable to expect a referring general practitioner (either in the community or within a custodial setting) to be the sole safety net for specialist referrals without having resources available to them to assist with tracking and progressing them.

**326.** To add further context to Dr Todd's role, it is to be borne in mind that as sole medical officer he was caring for prisoners at the West Kimberley Regional Prison, in circumstances where there were high levels of health issues, with approximately half the prisoners having a chronic illness. The maximum operational prison population was just over 220 prisoners.[202]

**327.** Dr Rowland ultimately agreed that there were missed opportunities in terms of achieving a cardiology review for Mr Yeeda. She agreed that Mr Yeeda required surgery.[203]

**328.** Dr Rowland also acknowledged that Mr Yeeda fell through the gaps. She provided the following perspective as to why Mr Yeeda's referral (be it the First Referral of the Second Referral) was not progressed (in addition to the lack of a tracking system for referrals especially the Second Referral) at the West Kimberley Regional Prison:

> "*Because the Derby Hospital didn't keep track of that, even though a copy went there. Because the cardiology service, which received it, didn't act on it at all other than to send a rejection notice of sort. So though the rejection notice does say, "We will continue to offer service and will see you", which may have suggested that an appointment may still have been forthcoming from them – and because the second referral, which was written to appears to have got lost – which is an accident – which unfortunately can happen. And therefore, there was, in the end, no referral to trigger an appointment.*" [204]

**329.** It was not the role of the Derby Hospital to progress the First Referral. A copy of the referral was emailed to the Derby Hospital Outpatient Service, where it was filed in the patient medical record. The cardiology referrals at the material time were managed by WA Cardiology, in accordance with their MOU with WACHS-K.[205]

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[202] Exhibit 1, tab 35.
[203] ts 217 to 218.
[204] ts 204; ts 208 to 209.
[205] Exhibit 2, tab 9.

**330.** The fact that the referral (be it the First Referral or the Second Referral), was not added to the Problem List on Mr Yeeda's EcHO records as outlined earlier in this finding, compounded the difficulty in tracking it even by the rudimentary means available at the material time. This contributed to Mr Yeeda going "*under the radar*" as articulated by Dr Rowland at the inquest.[206]

**331.** However, the failure to complete these details on the Problem List was not a primary contributor to Mr Yeeda going under the radar. This process was still reliant on human input of data into Mr Yeeda's EcHO records and a review of that data by the subsequent clinician(s) who opened those records, who would ideally have gone to the Problem List, cross checked and identified that his referral was still pending. There was still ample room for human error along this continuum.

**332.** The main issue is the lack of a robust referral tracking system. This requires some cooperation between the Department of Justice and WACHS, and I make further comment under the heading *Recommendations*, later in this finding.

**333.** I am satisfied that the Department of Justice missed an opportunity to facilitate the treatment and care of Mr Yeeda's rheumatic heart disease, by reason of not having in place a computer-based tracking system with an adequate recall system for managing prisoners who had urgent referrals pending, and/or prisoners who were over-boundary.

**334.** This was one of the factors that contributed to Mr Yeeda not seeing the Visiting Cardiologist, as ordered by Dr Todd, but it was not the primary factor. A computer-based tracking system is a fallback position, in the nature of a safety net, for when the usual processes do not result in an appointment being made.

**335.** The primary factors that contributed to the First Referral being missed are outlined below.

**336.** The steps being taken by the Department of Justice to rectify or reduce this risk in future are addressed later in this finding under the heading *Improvements: Department of Justice*.

[206] ts 196.

## WA Country Health Service-Kimberley

**337.** Dr Phillips prepared a report for the coroner and gave evidence at the inquest concerning WACHS-K's role in the medical management of Mr Yeeda.[207]

**338.** When Dr Todd referred Mr Yeeda to be seen by the Visiting Cardiologist, this was essentially a request to the external service provider that had been contracted by WACHS-K under the MOU. As outlined earlier in this finding, at the material time, those external cardiology services were transitioning from WA Cardiology to Perth Cardiovascular Institute.

**339.** At the inquest Dr Phillips' evidence was that WACHS-K carried all the responsibility for ensuring that there was a smooth transition of services, that WACHS-K feels accountable for the governance of Wait Lists and for specialist service management and that they could have done better.[208]

**340.** Specifically, in terms of where they could have done better Dr Phillips acknowledged that WACHS-K could have engaged in some strongly worded conversations and/or legal action in pursuance of that transfer and/or that they could have provided information about their concerns to the referring GP's.[209]

**341.** Through its lawyer the SSO, WACHS accepts that it bears the ultimate responsibility and accountability in respect of Mr Yeeda's First Referral not being actioned.

**342.** I am satisfied that WACHS had a significant role in ensuring that Mr Yeeda received an adequate level of medical treatment and care, and that included the progression of his First Referral to see the Visiting Cardiologist. That role included matters such as:

**a)** using stronger terms in its correspondence or escalating the matter regarding the adequate transition of services; and

**b)** separately providing information to the referring GP's about the issue, which would have alerted the GP's to the need to have their records checked to see if any cardiology referrals had been missed

[207] Exhibit 2, tabs 9 and 9A; ts 7 to 33.
[208] ts 16.
[209] ts 18 to 19.

in the course of the transition from WA Cardiology to Perth Cardiovascular Institute.[210]

**343.** Having regard to the above two matters, that were not undertaken, I am satisfied that WACHS (including WACHS-K) did not take all reasonable and proper steps available to it, to progress the First Referral and/or to mitigate the risk of it being missed, and this contributed to the First referral being missed.

**344.** However, WACHS through its lawyer the SSO, also submits that WA Cardiology's actions significantly contributed to Mr Yeeda's First Referral not being actioned and draws my attention to the following:

**a)** WA Cardiology did not transfer the Wait List information to Perth Cardiovascular Institute as requested in November 2017 and January 2018; and

**b)** WA Cardiology did not engage with Perth Cardiovascular Institute on the handover planning.[211]

**345.** My comments concerning the role of WA Cardiology appear immediately below.

**346.** The improvements implemented by WACHS-K after Mr Yeeda's death are referred to later in this finding under the heading *Improvements: Western Australian Country Health Service*.

## WA Cardiology

**347.** WA Cardiology was contracted by WACHS-K to provide specialist cardiology services for prisoners and therefore their actions, or inactions, may also be the subject of comment under s 25(3) of the Act.

**348.** At the inquest Professor Judkins testified that for its part WA Cardiology could have handled the transition of service better. Specifically, he considered that WA Cardiology could have communicated better with both WACHS-K and Perth Cardiovascular Institute in terms of its intent to continue to look after patients after the transition, given they already had a large presence in the Kimberley Region and were set up to do that. Professor Judkins felt WA Cardiology could have had a more open conversation about it.[212]

[210] ts 18 to 19.
[211] Exhibit 2, tabs 24 to 26.
[212] ts 67 to 68.

**349.** Professor Judkins agreed that WA Cardiology had a responsibility to assist in the smooth transition of the contract to the new service provider. He stated that he was reasonably comfortable with WA Cardiology's process of communicating back to the referring doctors (in Mr Yeeda's case, communicating back to Dr Todd).[213]

**350.** However, Professor Judkins also acknowledged that WA Cardiology's communications could have been clearer around the area of confidentiality, and more responsive in connection with requests made by Perth Cardiovascular Institute for assistance with the transition of service.[214]

**351.** WACHS, through its lawyer the SSO, draws attention to a number of factors in order to submit to me that WA Cardiology's role in the transition of the cardiology service was, essentially, unsatisfactory. WA Cardiology through its lawyer refers me to WA Cardiology's compliance with all of its stipulated contractual obligations.

**352.** As outlined earlier in this finding, s 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability.

**353.** I therefore make no comment on the matter of WA Cardiology's compliance with its stipulated contractual obligations.

**354.** In the area of patient care, there are overarching obligations regarding patient safety that ought to concern all clinicians, irrespective of specific contractual obligations (which are relevant in respect of rights and obligations of the parties to those contracts).

**355.** I accept the SSO's submission and in reaching this decision have had regard to the following:

**a)** WA Cardiology had 26 days in which it could have triaged the First Referral and acted upon it;[215]

**b)** WA Cardiology wrote to Dr Todd to advise of the change in service provider on 9 January 2018, after the 30-day time frame (the priority rating chosen by Dr Todd) had passed;[216]

[213] Ibid.
[214] ts 84 to 85.
[215] Exhibit 1, tab 37; Exhibit 2, tab 10A.
[216] Ibid.

**c)** WA Cardiology knew that, realistically, Mr Yeeda was not going to be conveyed to be seen by them in Broome;[217]

**d)** WA Cardiology's communication could have been better (examples include contacting Dr Todd directly, explaining to WACHS-K their concerns around confidentiality at the material time, for further consideration and discussion, passing on, at least the names of patients on the Wait List to WACHS-K, liaising with Perth Cardiovascular Institute as requested).

**356.** I am satisfied that WA Cardiology missed a number of opportunities to assist in the adequate transition of the Visiting Cardiology service from WA Cardiology to Perth Cardiovascular Institute, and that this contributed to Mr Yeeda's First Referral being missed.

## IMPROVEMENTS: DEPARTMENT OF JUSTICE

**357.** Dr Rowland has reported on a number of improvements undertaken by the Department of Justice since Mr Yeeda's death. Relevant improvements are outlined below.[218]

### In-reach Specialist Services

**358.** At the material time, the arrangement was for the Visiting Cardiologist to come to the Kimberley Region six times a year. The usual process was for the West Kimberley Regional Prison to send two prisoners at a time to Derby Hospital to see the Visiting Cardiologist. The West Kimberley Regional Prison Superintendent Coyne informed the court that he would facilitate a prisoner's attendance at Derby Regional Hospital for urgent medical attention. However, this is for unexpectedly urgent cases, upon the advice of Prison Health services, and rightly so. Ordinarily however, they were sent two at a time.[219]

**359.** It is also to be noted that in Dr Todd's experience, the arrangements for escorting prisoners to their external specialist appointments was the "*biggest problem*" in terms of achieving the consult. Dr Todd referred to the effect on the prison routine and the resourcing issues in the context of getting the prisoner to the external clinic.[220]

[217] ts 84.
[218] Exhibit 1, tab 41.
[219] Exhibit 1, tab 34; ts 271.
[220] ts 147 to 148.

**360.** After Mr Yeeda's death and following a meeting between the Department of Justice (Health Services), WACHS-K and Perth Cardiovascular Institute, in-reach visits by Perth Cardiovascular Institute commenced at the West Kimberley Regional Prison, inclusive of in-reach echocardiograms and cardiologist reviews. This allows for greater prisoner access, without the need for prisoner transport to an external location. The visiting clinicians have access to the prisoners' medical records on site and can provide immediate information about a clinical management plan, following up with a formal letter afterwards.[221]

**361.** By reason of this improvement, which is already implemented, it is unnecessary for me to make a recommendation concerning the implementation of in-reach specialist services at the West Kimberley Regional Prison.

**362.** An assessment of in-reach specialist services at regional prisons across Western Australia is outside the scope of the inquest. However, by way of comment, the positive developments at West Kimberley Regional Prison should give some impetus to an assessment of the feasibility of more in-reach specialist services across the State prison system.

## Rheumatic Heart Disease Reviews

**363.** The Department of Justice has developed documentation templates, with prompts to facilitate comprehensive reviews, specific to rheumatic heart disease, as follows:

**a)** a comprehensive annual review by the Prison Medical Officer; this template is based upon the Kimberley Aboriginal Medical Service Clinical Protocol for rheumatic heart disease and is consistent with clinical guidelines in the area; it covers matters such as the prevention of recurrences of acute rheumatic fever with penicillin injections, the prevention of endocarditis, the early detection and management of complications, and ensuring that pneumococcal and influenza vaccines are up to date; and

**b)** a cardiac care plan for the three-monthly nurse care plan visits; this is to be used at three monthly intervals, in the course of the nursing review, for addressing a range of factors, starting with the prisoner's cardiovascular condition;

[221] Exhibit 1, tab 41; ts 160 to 161; ts 201 to 202; ts 260.

**c)** a rheumatic heart disease care plan, which includes the prompts for regular penicillin injections, the annual Prison Medical Officer review, echocardiography and cardiology referrals.[222]

**364.** The Department of Justice has also undertaken staff education on rheumatic heart disease, cardiac failure and cardiac arrhythmias, and made links available to the relevant guidelines within the EcHO records. At the inquest Dr Rowland explained that cardiac disease within the Kimberley prison population is common and there are complexities in the management of the prisoners' health, including continuity in the context of prison transfers. Staff education has included the importance of arranging reviews, and the referral process.[223]

## Referral Tracking

**365.** The Clinical Nurse Manager at the West Kimberley Regional Prison recognised the importance of keeping a track of referrals. She informed the court that she now has more involvement with referrals. Her practice now is to periodically go through the outstanding referrals and follow them up by sending a waitlist of prisoners to the external provider.[224]

**366.** This is a sound approach. However, this is not a function that can be addressed fully by individual approaches across the State. A system needs to be in place to comprehensively manage the tracking of referrals to external specialist services.

**367.** The Department of Justice recognises that tracking referrals to external specialist services remains a challenge for Health Services, and draws my attention to processes already in existence, and planned improvements, in the area of tracking.

**368.** The processes already in existence to minimise the risks associated with delays include:

**a)** the requirement to record referrals on the prisoner's active Problem List in their EcHO records, so that this information is readily visible to all clinicians opening that record; a pre-existing requirement at the time Dr Todd was treating Mr Yeeda; and

**b)** the requirement to have appropriate recalls (interventions) in place for the review of the prisoner, to enable reassessment and

[222] Exhibit 1, tab 41; ts 227.
[223] Exhibit 1, tab 41; ts 227 to 228.
[224] Exhibit 1, tab 34.

> adjustment to the management plan if the clinical status changes, and to ensure delays are identified; this intervention process was not available to Dr Todd at the time he was treating Mr Yeeda;[225]

**369.** The Department of Justice recognises that the above processes for tracking referrals are heavily reliant upon individual staff knowledge and compliance. They are vulnerable to omissions.[226]

**370.** Dr Rowland informed the court that other technical tools presently exist within the EcHO record system, to track referrals and improve visibility. A project to implement the use of these tools commenced (the Referral Tracking System Project). The purpose of the Referral Tracking System is to enable the clinician to check the status of a referral at any point in time.

**371.** At the inquest Dr Rowland explained that the Referral Tracking System has not been "*switched on*" because there are concerns about the accuracy of the information available to the Department of Justice. It has been delayed by the requirement to establish an accurate and timely source of truth from the Department of Health and WACHS regarding the status of referrals and outcomes of appointments, to maintain accuracy of the tracker.

**372.** At the inquest Dr Rowland also outlined the resourcing constraints at the Department of Justice that are contributing to the delay of the implementation of the Referral Tracking System.[227]

**373.** I have addressed these aspects under the heading *Recommendations*, later in this finding.

## IMPROVEMENTS: WA COUNTRY HEALTH SERVICE

**374.** Dr Phillips has reported on a number of improvements undertaken by the Department of Justice since Mr Yeeda's death. Relevant improvements are outlined below.[228]

[225] Exhibit 1, tab 41; ts 160 to 161
[226] Exhibit 1, tab 41.
[227] ts 201
[228] Exhibit 2, tabs 9 and 9A; Exhibit 8.

## State-wide Central Referring Service

**375.** Dr Phillips informed the court that in her view, the one change to prevent this happening again would be a system that operates as a single-entry point for all referrals into an electronic database. The current system is manually based and prone to human error. There are dual pathways in place for private and public referrers.[229]

**376.** At the inquest Dr Phillips explained that all referrals are stored on the WACHS WebPas system, which is their patient administration system. Some referrals are made electronically, and some are paper based. Further, external entities use different databases.[230]

**377.** After the inquest Dr Phillips reported to the court that the Department of Health has recognised the risk inherent in manual systems and has been working towards electronic medical records. WACHS-K has sought to be a pilot site for the implementation of the Central Referring Service for both public and private referrals to all specialist services, including contracted services.[231]

**378.** The Central Referring Service is being rolled out in stages and is the precursor to the planning for a larger technology enhanced change referred to as the Smart Referral system, which Dr Phillips understands is intended to capture all referrals to the Central Referral Service (whether private, public or contracted referrers) within an online platform.[232]

**379.** By reason of the improvements already under way in this area, it is unnecessary for me to make a recommendation concerning the consideration of the implementation of a system such as the Central Referring Service by WACHS.

## Improvement to the process for seeing a specialist

**380.** Dr Phillips informed the court of a clearer pathway for sending referrals. The requirement now is for all cardiology referrals to be sent directly to the external provider, Perth Cardiovascular Institute. This is made clear on the documentation being used by the referring clinicians. Formerly some referrals were being sent to the regional hospitals where the prisoners were going to be escorted, to be seen by the visiting specialist.

[229] Exhibit 2, tabs 9 and 9A; Exhibit 8; ts 19 to 20.
[230] ts 23.
[231] Exhibit 8.
[232] Ibid.

Those regional hospitals were not uniformly tasked with on forwarding the referral to the external provider.[233]

**381.** Since 2019 WACHS-K has implemented an audit involving their WebPAS computer records and Perth Cardiovascular Institute's records, to cross check and make sure there are no other referrals that had initially been sent to WA Cardiology (that appear on WebPAS) remaining unactioned. It initially appeared to WACHS that there were approximately 400 referrals that may not have been passed on to Perth Cardiovascular Institute. Self-evidently, an audit was critical.[234]

**382.** WACHS-K has established a Wait List Governance Subcommittee which actively monitors the progression of referrals to Perth Cardiovascular Institute by requiring Perth Cardiovascular Institute to regularly provide:

**a)** the Wait List; and

**b)** the over-boundary reports.

This is an important initiative because, pending the full implementation of the Central Referring Service and the Smart Referral system referred to immediately above, there would otherwise be still a risk of a referral being missed, inadvertently. The functions of the Wait List Governance Subcommittee should operate to substantially mitigate this risk.

**383.** At the inquest Dr Phillips explained that this forum also makes it very clear that the patients are WACHS-K patients (to avoid the confusion that appears to have developed earlier with WA Cardiology forming the view that the patients were exclusively theirs).[235]

**384.** A further improvement, that operates to support the functions of the Wait List Governance Subcommittee, concerns the role of the Procurement and Contract Management Directorate of WACHS. After Mr Yeeda's death this directorate reviewed existing contractual arrangements to ensure that appropriate clinical governance is in place. There should be no future conflict over the question of the availability of a Wait List[236]

**385.** WACHS-K has established a Rheumatic Disease Governance Committee and is exploring alternative models of care with the aim of seeking to

[233] Exhibit 2, tab 9A.
[234] Exhibit 2, tab 9A; ts 13.
[235] Exhibit 2, tab 9A.
[236] Exhibit 7; ts 24.

reduce the high rate of non-attendance at specialist appointments. This initiative would need to tie in with information about whether the individual's non-attendance is by reason of being in custody. One of the alternative models of delivering cardiology services in the region includes an exploration of the feasibility of directly employing cardiologists in the region (instead of relying solely on Visiting Cardiologists).[237]

## COMMITMENT TO ABORIGINAL YOUTH WELLBEING

**386.** Mr Yeeda's mother has referred to the importance of culturally safe care and family support. She feels that in order to have opened up about his health, Mr Yeeda needed to be able to speak with Aboriginal doctors and nurses. An Aboriginal health worker or liaison officer may have been able to help Mr Yeeda understand how important it was to take care of himself.[238]

**387.** In its March 2022 response to my *Inquest into the deaths of 13 children and young persons in the Kimberley*, and *Learnings from the Message Stick: the report of the Inquiry into Aboriginal youth suicide in remote areas*, the State Government outlined its *Commitment to Aboriginal Youth Wellbeing* (Commitment Response).[239]

**388.** In its Commitment Response the State Government referred to culture being at the heart of Aboriginal Communities and addressed a range of initiatives in the health and mental health areas. Commitment 5 was made in connection with *Building capacity in health and mental health services*. Comments made in respect of that commitment include the following:

> "*We will improve the capacity of agencies, service providers and community organisations to deliver services to Aboriginal people that are flexible, responsive and culturally safe. Increasing the proportion of Aboriginal employees in the health and mental health fields will be a high priority, especially in remote areas.*"[240]

**389.** By reason of the commitments made in the Commitment Response, which represent a significant improvement towards the delivery of health services to Aboriginal persons in regional and remote areas, it is

[237] Exhibit 4.1 and 4.2; Exhibit 7; ts 24.
[238] Exhibit 5.
[239] https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/aboriginal-youth-wellbeing
[240] Ibid.

unnecessary for me to make a recommendation concerning the importance of culturally safe health services.

## RECOMMENDATIONS

### Referral Tracking System project

**390.** The Department of Justice's Referral Tracking System project is an important initiative, aimed at avoiding prisoners falling through the gaps and missing out on vital medical care and treatment. It is a tool that will be made available to the Prison Medical Officer. It is outlined under the heading *Improvements: Department of Justice*, above.

**391.** Dr Rowlands explained that the Referral Tracking System project at the Department of Justice has been delayed by the requirement to establish an accurate and timely source of truth from the Department of Health and WACHS regarding the status of referrals and outcomes of appointments. The Central Referring Service that is being piloted with WACHS aims to capture this information.

**392.** I therefore make the following recommendation in furtherance of the progression of the Referral Tracking System project at the Department of Justice, with the cooperation from WACHS:

***Recommendation No. 1***

**That the Department of Justice and the WA Country Health Service consider working together, and with such other entities as they may consider appropriate, to facilitate the provision of information concerning the status of external referrals and outcomes of external appointments to the Department of Justice (Health Services), and that issues of confidentiality be addressed, to progress the Referral Tracking System**

**393.** Dr Rowland also explained that the speed at which the Department of Justice's project for the referral tracking system progresses will be dependent upon the allocation of human resources at the Department of Justice. As at the time of the inquest Dr Rowland explained that there was no allocated project officer and that within the Department of Justice, she was the only person allocated to the project. This resourcing

issue was a matter also raised in the inquest into the death of Jeremy Michael SCOTT.[241]

**394.** I therefore make the following recommendation, in support of the recommendation already made in the inquest into the death of Mr Scott:

> ***Recommendation No. 2***
>
> **That the Department of Justice considers allocating sufficient resources to enable a project team to be established to finalise the work currently being undertaken by Dr Rowland to progress the Referral Tracking System.**

### *Fitness for sport or work*

**395.** At the inquest it was evident that custodial officers would be assisted by some guidance on the fitness for sport or work, in respect of the prisoners under their care.[242]

**396.** Whilst the custodial officers can, on an individual basis instigate their own search of the Alerts in an individual prisoner's TOMS records, a comprehensive and updated list of the Alerts for fitness for sport or work, in respect of the prisoners under their care, would improve their management of them.

**397.** I therefore make the following recommendation in furtherance of the more comprehensive management of prisoners' Alerts:

> ***Recommendation No. 3***
>
> **That the Department of Justice considers the feasibility of making a list available to custodial officers that outlines any Alerts as to the unfitness for sport or work, that confidentiality issues be addressed, and that guidance be given to the officers on the purpose and expected response to such an Alert (for example, guidance as to when an officer ought to act in a particular way).**

[241] [2021] WACOR 34; ts 201.
[242] ts 267 to 269.

## CONCLUSION

**398.** Mr Yeeda died in custody in May 2018 at a young age from rheumatic heart disease, that had resulted in severe aortic valve regurgitation. It is a disease that has been almost eradicated in the non-Indigenous populations of developed countries. He was in need of heart valve replacement surgery since approximately 2014 when it became clear he had developed severe aortic valve regurgitation. With the passage of time that need became more urgent.

**399.** Since 2015, attempts were made to arrange heart valve replacement surgery for him, and two such surgeries were planned (in 2015 and in 2016). For various reasons, there was no consent for that scheduled surgery by or on behalf of Mr Yeeda.

**400.** In June and July 2017, at the early stage of his adult custodial term, when he was at Albany Regional Prison, Mr Yeeda refused to take the recommended steps to see a cardiologist, wanting his family to be with him to explain what the doctor would say. He was still just 18 years old, away from country, and may have been apprehensive about the discussions concerning surgery on his heart.

**401.** Mr Yeeda's family were based in the Kimberley Region. When Mr Yeeda was transferred to the West Kimberley Regional Prison, he promptly agreed to see a cardiologist and a referral was made for him in early December 2017.

**402.** This referral was not progressed, and Mr Yeeda sadly died approximately five months later. It is likely that his death would have been prevented if he had been seen by the Visiting Cardiologist and if he had agreed to undergo heart valve replacement surgery.

**403.** I received evidence at the inquest concerning Mr Yeeda's past lack of engagement with health services in the community (be it his penicillin injections, the recommended cardiology appointments and/or his scheduled surgeries). For much of that period he was not yet an adult, and on some occasions, he was unable to attend due to being in custody. On other occasions, away from the Kimberley Region, he elected not to engage.

**404.** At a general level there can be various reasons as to why Aboriginal persons are not able attend scheduled health services appointments, and many of these are based on hardship as opposed to a lack of attention to the time frames. It is important to keep encouraging this engagement, and not to assume that a history of lack of engagement will keep repeating itself.

**405.** It is my hope that by increasing the proportion of Aboriginal employees in the health sector, especially in remote areas, there will be more culturally relevant communications and a greater and more comfortable level of engagement will be seen.

R V C FOGLIANI
**STATE CORONER**
20 JULY 2022